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Vol. IV. MARCH, 1905 No. 12

DETROIT MEDICAL JOURNAL

The Practitioner's Monthly

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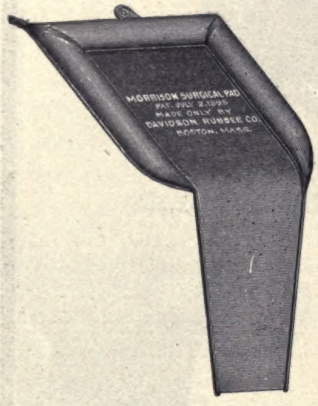

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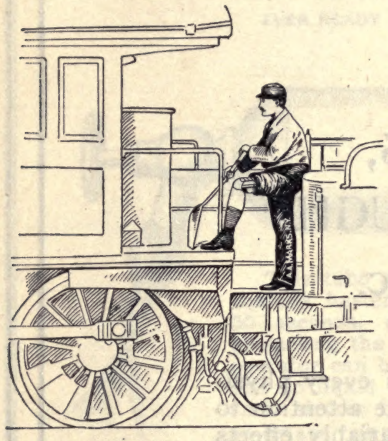

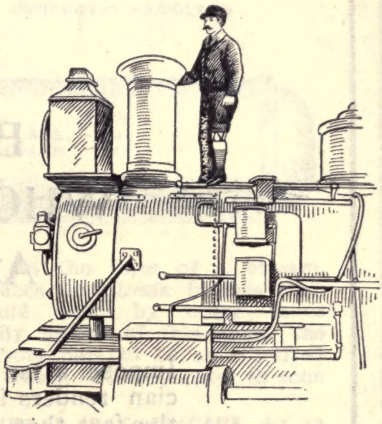

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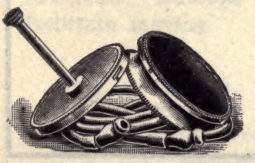

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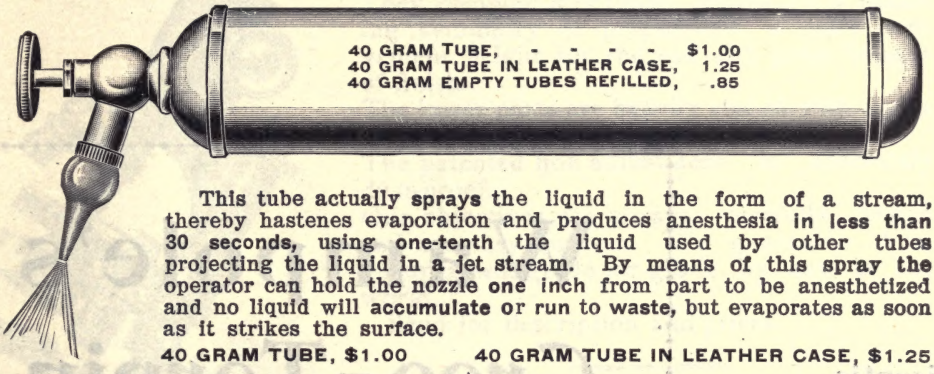

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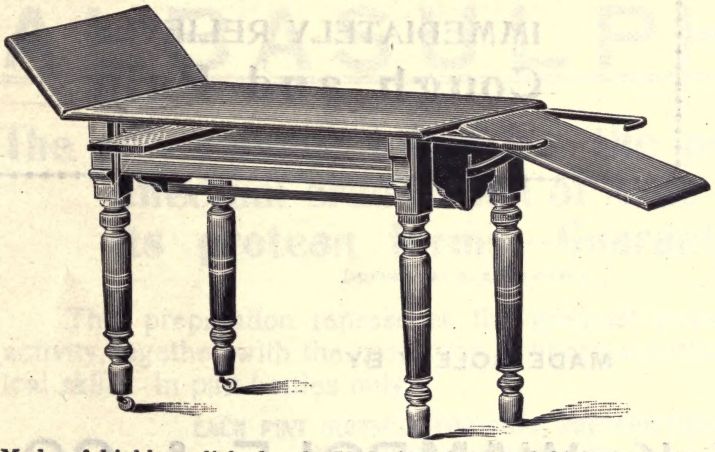

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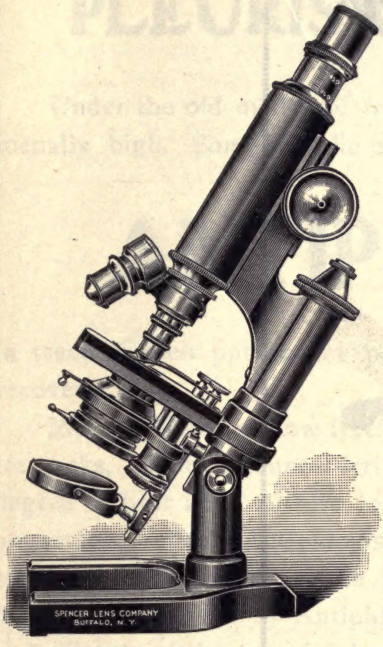

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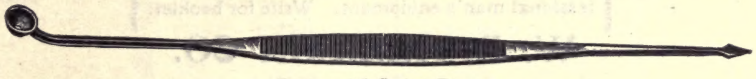

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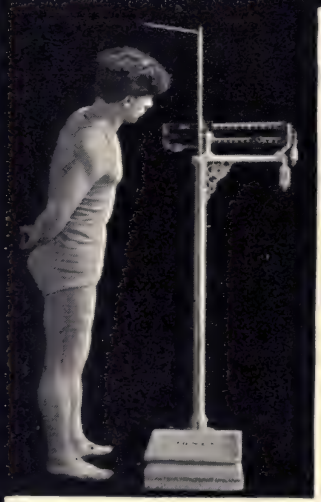

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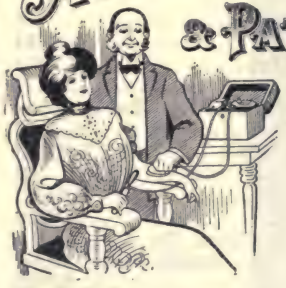
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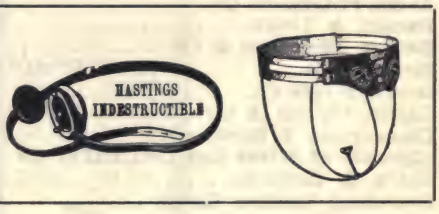

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THE DETROIT MEDICAL JOURNAL.

VOL. IV. MARCH, 1905. No. 12

CANCER AND SARCOMA AS AFFECTED BY LOCALITY.*

By THEODORE A. McGRAW, M. D.
Detroit, Mich.

As a thistle infects a field by pushing its roots and scattering its seed in every direction, so a malignant tumor, beginning as a small abnormal cellular growth, will infect all of the surrounding tissues by growing into the lymphatic spaces and blood vessels and finally by sending detached cells or nuclei into the lymph or blood currents. What causes the primary tumor is one of the most profound mysteries of pathology. It makes its appearance sometimes at the seat of some injury or inflammation, but often without warning in apparently healthy tissue.

From this primary nodule spring a multitude of secondary growths which finally destroy the patient. If, however, the primary nodule is removed early, together with all surrounding tissues in which secondary foci of disease have been developed, a cure will take place and the patient may live many years without a recurrence and without the development of any new growths. If we could trace the seeds of disease in all their wanderings and remove them all, we should be able to cure cancer. They are often, however, widely distributed when the primary tumor is first discovered, or at least when it first comes to the surgeon for examination. For this reason we attain success with our most radical operations in only a minority of our cases. It is, however, a gratifying fact that this minority is growing larger every year, as diagnosis becomes more certain and treatment more thorough. It is the exceeding rapidity with which the more malignant varieties of cancer and sarcoma mature and scatter seed that makes their early diagnosis and removal so important.

The difficulties of diagnosis are, in part, inherent, so much so that the most experienced surgeon may find himself in great doubt as to the nature of a small lump deep in the flesh, but they arise also in part from a lack of careful discrimination and study of symptoms. I can not hope, in a paper like this, to give an exhaustive report of the numerous forms assumed by malignant disease in various parts of the body, but is seemed to me when accepting your kind invitation to read a paper before you this evening, that I could not choose a more interesting theme than the diagnosis of cancer and sarcoma as modified by their place of location, for the reason that the symptoms manifested by these growths vary much as they are acted upon by their environments. The phenomena presented by an epithelial cancer of the tongue differ from those of an epithelioma of the lip; those of a sarcoma of the cranium from those of a sarcoma of the femur; and those of scirrhus of the breast from those of scirrhus of the uterus. It is only by a careful study of the tumefacetions and ulcerations which occur in any given organ that we can become expert in discriminating the benign from the malignant forms.

*Read before the Northern Tri-State Medical Society, Toledo, Ohio, Jan., 1905.
Detroit, Mich., March 15, 1905.

Cancerous growths are not common on the hairy scalp; when they occur it is usually in the form of an epithelioma secondary to some more benign form of ulceration. They might possibly be confounded with gummata, but are more superficial. They form irregular ulcers with hard edges and tend slowly to enlarge, whereas the gumma begins as a doughy swelling which in time breaks down and forms a sore with undermined edges. There is a form of sarcoma which springs from the cranial bones, which is not altogether uncommon. In their early stages they may cause intense headaches by pressure on the brain. Later on they destroy the bone and grow into th dura mater below and into the scalp above. They are then soft, diffused tumors which sometimes cover a large portion of the head and give a deceptive sense of fluctuation. The exploring needle, if inserted, lets out much blood but no pus. If the surgeon should be so incautious as to cut into the tumor he would find only a mass of soft, vascular tissue between him and the brain.

If detached and diagnosticated when small, they may be removed with the adjacent rim of sound bone; some of these sarcomas are of very slow growth. I have a patient with whom such a tumor occurred first in the ethmoid. It was removed by another surgeon. It recurred in a year and I removed the new growth which then occupied the lower central portion of the frontal bone. On its second recurrence I removed the left eye and the upper wall of the orbit, and subsequently some more of the frontal bone. The forehead is now occupied by a large bulging tumor, which afflicts but does not yet destroy the patient, a girl of twenty-two, although it is now five years since its first appearance.

Those sarcomas of the eye which result from injuries are apt to progress far before their true nature is detected. The reason of this is that the symptoms of tumor are at first concealed by those of inflammation. The eye becomes closed and is examined with difficulty, and when finally the practitioner becomes alive to the gravity of the case, the disease has invaded the orbit. On the other hand, those tumors which develop from internal causes are detected earlier, because the patient becomes alarmed at the growing failure of vision, and soon consults an oculist, who determines the diagnosis by an ophthalmoscopic examination.

The epitheliomas of the eyelid begin either as a papule which is soon followed by an ulceration, or by an ulceration with hard edges. They are exceedingly malignant and recur after extensive operations. These troubles are intensified, often, by the practice of some physicians of touching such places with mild caustics. I wish here to express my conviction that the malignancy of epithelial growths on mucous membranes is greatly intensified by any application which does not destroy them root and branch. A caustic which does not destroy the disease weakens the power of resistance. I have seen cancers of the lip begin to grow and spread furiously after such treatment. A swelling on the eyelid is either an accumulation of secretion in one of the glands, or an inflammation, or a cancer. The cancer differs from the others in its slow development, in its lack of inflammatory symptoms and in the warty character of its growth. An ulcer on the lid is almost always a cancer or rodent ulcer, but may in rare cases be tuberculous or syphilitic.

There are scabby spots, usually multiple on the faces of old people, which develop frequently into epithelial cancers. They are, in fact, mild aggressive growths of epidermis which become cancer when the corium loses its power of

resistance and permits the growth of the epidermal cells through its structures. Malignancy in these cases develops slowly and the disease may last twenty years before the patient dies from its effects. Before ulceration takes place, the affected area may be safely treated by the application of pure chromic acid. After the ulceration has occurred, they should be removed by wide and deep excision.

On the lip, as on the eyelid, cancer may begin as a papule or an ulcer. A warty growth on the lip is rarely anything else than an epithelioma, but the cancerous ulcer is sometimes more difficult to diagnosticate. I have seen hard chancres mistaken for cancers. These affections, however, are round, shallow ulcers with indurated edges and often surrounded by an inflammatory zone, while a cancer is irregular in shape and grows less rapidly. The neighboring glands in syphilis enlarge almost as soon as the primary sore appears, while those of cancer are barely perceptible after many months. Finally, the chancre occurs more often in youth, while the cancer is a disease of more mature years. The most difficult cases to decide are those chaps of the lip which are slow in healing and persistent and which sometimes mark the beginning of malignant disease. When they refuse to heal they should be excised and subjected to microscopical examination.

The cancers of the tongue may be confounded wth gummas and tertiary ulcers. These lesions of mouth and tongue syphilis, are, however, usually multiple from the beginning, while cancer becomes multiple as a rule only after infection of the neighborhood has taken place. The cancer occurs most frequently on the side opposite the molar teeth, when it supervenes on a syphilitic ulcer the best surgeon may fail to recognize it in the early stage.

A disease which in the long run will often develop into cancer is Leucoplakia. It occurs in the mouth as a white spot on the mucous membrane, looking in the early stage like the film left by skimmilk, but later having the denser white of white paint. Leucoplakia is apt to spread over the whole cavity of the mouth, and unfortunately is rarely recognized until the mucous membrane become irritated and painful. The disease ought to be stamped out at its first appearance. I use for that purpose the actual cautery. I have seen the same trouble on the mouth of the woumb. Cancer often arises on the side of the tongue in the form of a small ulcer, which the patient may attribute to injuries received from the sharp edges of the teeth. Now when we consider the extremely rapid development of cancer of the tongue, it becomes evident that the surgeon who would save his patient must operate at the very earliest moment. Cancer of the tongue may kill in six months or a year, while cancer of the lip if unmolested will give an average length of life of five years, and epithelioma of the integument of ten years or more. I do not think that any experienced physician could mistake the small painful aphthous ulcers of the mouth for cancer, but when an ulcer of irregular shape becomes persistent on the edge of the tongue, and resists treatment for more than three weeks, it should be cut out. The operation is trivial, the danger of delay very great. It must be remembered that the lymphatic glands which are first affected in these cases are the deep glands of the neck and should be sought for along the large blood vessels.

The cancers which occur on the back part of the tongue and on the tonsils and pharynx are usually classed with the ordinary catarrhal throats until they become painful and incurable. They might

be mistaken for tubercular or syphilitic nodes or ulcers and, until the diagnosis has been made out beyond peradventure, the surgeon should be guarded in his prognosis. A woman entered St. Mary's Hospital with an ulcer which extended across the pharynx and on to both tonsils. The lymphatic glands on both sides of the neck were swollen, swallowing was very painful and difficult, and the breath was foetid. There were no evidences of syphilis or tuberculosis. I diagnosed an epithelial cancer of the pharynx and regarded it as inoperable. She recovered completely under the use of the X-Ray by Dr. Cooke, and I am still uncertain as to the nature of the trouble. Patients presenting such symptoms, however, are usually the subjects of cancer, and persistent ulcers on the pharynx or tonsils should arouse the suspicion of the physician.

There is no class of cancers in which mistakes occur so constantly as in tumefactions of the breast. Twenty-five years ago the habit of the general practitioner was to disregard the cancers in their early stages and to let the golden opportunity for operation pass by. This occurs occasionally even now, but in general the error today is made in the other direction. The profession has become so imbued with horror of malignant disease that the practitioner sees a cancer in every swelling of the mammary gland. I hardly venture to report the number of cases which have come under my observation in which neurotic, inflammatory and cystic disorders have been mistaken for malignant disease. There is a class of nervous women who become exceedingly alarmed over a tenderness of the breast associated with congestion. Both breasts are apt to be involved, but in one the trouble is usually more marked than in the other, so that the symmetrical organs may even differ in size. This difference in size, however, is normal in some women but may not be remarked until the attention becomes fixed upon it by soreness or pain. Some of the lobules may be more swollen than the others and cause the inexperienced surgeon to think that he feels a tumor. There is a method of examination which I learned years ago from an English surgeon, which has been very useful. If you grasp such a gland with its swollen lobules, the thickened structure will feel like a tumor, but if you press the gland against the ribs with your flat hand, you will find that while the breast may be unusually firm, it contains no well defined lumps.

These congestions are sometimes associated with uterine troubles, and may be in some cases due to reflex action and be sympathetic in character. This is, however, by no means always the case. Women, especially with pendulous breasts are liable to suffer little injuries which produce chronic inflammations, and cases occur in which the cause of trouble is exceedingly difficult to discover. The local treatment of this kind of disorder is support and gentle compression, at first by adhesive plaster, and afterwards, when the acute symptoms have subsided by proper bandages and supports, by applications of belladonna and by gentle massage. All uterine and ovarian irritations should be relieved and the general health closely looked after. Another form of inflammation is that in which the whole organ becomes slowly caked and hard. This trouble is slow in developing. The extreme hardness of the gland and its contraction reminds one of scirrhus. It differs from all forms of cancer, however, in these respects, the hardness affects the whole breast but causes no retraction of the nipple, there is no involvement of the skin, and the axillary glands in many cases are not affected.

It is characteristic of these cases that microscopical examination does not de-

cide the diagnosis. Virchow speaks of these cases as diffused fibromas and notes that they simulate scirrhus under the microscope by showing what seems to be alveolar spaces filled with epithelial celis due to the formation of fibrous tissue around ducts and acini. In some cases this interstitial mastitis involves only certain lobules and not the whole breast. In such, an exploratory operation should be made and the lobules affected removed and carefully examined. The gross appearance of fresh sections if the trouble is inflammatory will be like that of fibrous tissue.

In some women the nipples are undeveloped and apparently retracted from early childhood. This must be borne in mind when making a diagnosis. The mammary gland is subject also to irritations of the mucous membrane lining the ducts and acini, which give rise to collections of fluid. In the vast majority of cases these are inocuous gatherings and may be cured by repeated punctures with an exploring needle. When situated deep in a large, flat breast, they are frequently mistaken for cancer. The exploratory puncture will decide the matter. Some surgeons are afraid to make such punctures lest they thereby make a channel through which cancer cells may excape and infect surrounding structures. This in my opinion, is an error. If scirrhus exists with a perceptible growth, the breast is already infected. In any event, its detection should be followed by immediate operation. Only in cases where there is a suspicion of an encapsulated sarcoma would there come any immediate danger from this cause. When the puncture of a cyst is followed by the entire disappearance and collapse of the tumor, the surgeon may reassure the patient, without, however, losing sight of her.

If, however, there is any lump or induration left after the evacuation of the fluid, an operation should be done at once. An incision into the tumor will usually decide its character, and the operation can be competed according to the indications thereby revealed. It is very important that correct diagnoses are made before advising operations. The cancer quacks get the popular reputation which they enjoy largely from mistakes of regular physicians. When reputable men urge patients to have breasts, which are the seats of benign swellings, treated as cancerous, they establish the diagnosis on which the quack who applies his caustic may safely act. The caustic destroys the swollen organs, the patients recover, there is no further evidence of disease, and the faith of the community in the plaster "which draws the cancer out by the roots" becomes fixed and firm forever. This consideration alone should be sufficient to put the physician on his guard aganst a too pessimistic prognosis. Every swelling in the mammary gland requires immediate attention, careful study and appropriate treatment, but it does not warrant that radical procedure which has been lately urged for all cases of doubt, of amputation without diagnosis. The honest physician should learn to diagnosticate these various conditions and to apply his treatment to the necessities of the case. The cancer quack applies his horrible plasters to all swellings, and calls them all cancer.

Cancers of the stomach and intestines yield no symptoms which enable us to make an infallible diagnosis before operating. When having their seat at the pylorus, they cause gastric obstruction, followed often by gastric dilatation and ptosis. The results of these conditions are frequent vomiting, often many hours after taking food, and gradual starvation and emaciation. The pylorus, however, and the duodenum beyond it, are subject to many other diseases which cause obstruction and which make themselves

manifest by the same phenomena. Benign tumors, ulcers and scars, flexions and displacements of the bowels, inflammations caused by gall-stones, and even atony of the stomach walls may produce the same symptoms. The absence of hydrochloric acid in the test meal is no criterion by which we may be guided. I have seen undoubted cancers with free secretion of muriatic acid, and many cases of benign obstruction in which it was absent. Even after opening the abdomen the surgeon may be left in doubt, as tumefactions of innocent character may occur which simulate the cancerous growths and which are accompanied by glandular swellings.

It is, however, not necessary that the operator should diagnosticate the exact character of an obstruction before proceeding to relieve it, for in all such cases death is caused not from the direct effects of the disorder but from the obstruction which it produces. While the character of an obstruction is generally doubtful, there are, nevertheless, in many cases groups of symptoms which enable the surgeon to form a probable diagnosis. A painless obstruction in persons over forty years of age, with dilatation of the stomach and a perceptible tumor and accompanied by a rapid loss of weight, points to cancer. The occurrence of blood in the vomit has no diagnostic significance, for the reason that it is found also in cases of ulceration. A previous history of severe pain after eating and the presence of tenderness in the epigastric region make probable the existence of an ulcer. It must not be forgetten, however, that cancers often follow upon an ulceration.

It is more important to diagnosticate the location of an obstruction than its cause. In pyloric obstruction there is an absence of bile in the vomit, so also in a stenosis of the duodenum proximal to the orifice of the bile-ducts. Below that point a duodenal obstruction is marked by the presence of bile in the contents of the stomach and also by a distension in the epigastric region which extends far to the right of the median line.

Malignant disease is comparatively rare in the jejunum or ileum, but occurs often in the large intestine. Here it causes first a growing constipation with a dull uneasiness n the bowels—afterwards an obstruction which may either increase slowly until it becomes complete or which may suddenly end with a total closure. I have seen cancers of the colon, which had not even been suspected, cause an obstruction, all at once, which necessitated immediate operations. In many cases, however, the final catastrophe is ushered in by weeks of intermittent colicky pain. Where a tumor can be felt, the diagnosis is not difficult. An examination of the upper rectum should never, in these cases, be omitted.

Tumors may occur in the walls of the viscera which do not obstruct. In these cases, when there is no percepttible lump, it may be impossible to explain the disturbance in digestion until the cause is rendered evident by an exploratory operatory operation.

All cancers of the large intestines may cause hemorrhages which may be noted in the stools. Discharges of mucous and pus and shreds of tissue are also common, but are often ascribed to piles.

Evacuations of this sort always demand a thorough examination of the lower bowel, if necessary under an anaesthetic. With two fingers in the rectum, the hard tumor of a high rectal cancer may be felt, and with a long speculum even the lower end of the sigmoid may be rendered accessible. Rectal cancers may be confounded with the adenomata which are not uncommon in this region, but as both require the same treatment, the mistake is not serious. It is much more im-

portant that we should learn to distinguish them from the ulcerations of syphiis.

They differ from them in their more rapid course and in their speedy involvement of the perirectal tissues. Syphilitic ulcerations extend as multiple sores in the rectum, which gradually coalesce, while cancer involves the bowel as a continuous disease. The cancer, too, has more of a tumor. The history of the case will also throw light on the matter.

Cancer and sarcomas of the body of the uterus will often present symptoms simulating sub-involution, and even pregnancy.

The cancer of the uterine body is scirrhus. Usually it shows itself first as an irregular discharge of pus, mucus and blood and a gradual hardening of the organ. When such symptoms make their appearance, the discharge should be carefully examined by a competent microscopist. Pain is not constant, neither are the discharges always profuse. I saw a woman of thirty, once, with Dr. Brady, who was the picture of health and who was unconscious of any serious trouble until it was accidentally discovered that she had uterine cancer.

On examination, I found remaining a mere shell of the womb, the disease having destroyed it and involved all of the surrounding tissues. She had suffered no pain, had little discharge, and attended without discomfort to all her household dûties. Morbid vaginal discharges mean invariably something wrong and should never be neglected. If the diagnosis can not be made otherwise, the uterus should be curetted and the resulting debris subjected to a searching examination. Sarcomas of the uterine body may be mistaken for pregnancy and vice versa. They grow often about as fast as the pregnant uterus, they cause hemorrhages only when they protrude into the uterine cavity, and the pressure they exert on the blood vessels will sometimes cause a dark hue of the vagina. They frequently supervene on fibrous tumors. On the other hand, pregnancies accompanied by irregular bloody discharges in women at the climacteric may present the symptoms of sarcoma. These cases are exceedingly difficult to treat for the reason that the surgeon fears on the one hand lest he should produce a miscarriage, and on the other lest he should fail to remove a malignant tumor in its early and curable stage. It would be less difficult to diagnosticate these conditions if accurate histories of these disorders could be obtained.

This is usually impossible. A woman comes to the surgeon with an enlarged uterus. He finds it impossible to learn the duration and rate of growth. The organ may be adherent to all of the surrounding structures. He has to determine whether this indurated mass is the result of inflammation or of malignant disease, without any positive knowledge of what has gone before. When the cervix is the seat of disease the case is different. We have, then, tissues which are accessible to the eye and the finger.

The usual cancer at this point is the epithelial, and it manifests itself, as in other mucous membranes, by an ulcer or a warty growth. I have seen the enlarged follicles which often are seen at the neck of the womb, as the result of slight irritations mistaken for cancer, and have known of hysterectomies which have been done for this condition under that misapprehension. Even microscopic examination may lead astray in these cases for the reason that sections through tissues so rich in glands, which have undergone inflammations of a catarrhal form, may show alveolar spaces crowded with epithelial cells and looking like cancerous nests. The gross appearance of the tissues is not, however, the same as that of cancer. While the follicles are enlarged, they are not like warty growths, neither

are they inclined to disintegration with the formation of deep ulcers. Epitheliomas of the cervical neck frequently present themselves under the guise of great masses of granulations; when these are scraped away, the tissues are found to be deeply eroded and destroyed; there can be no question of diagnosis when the surgeon finds this condition.

While exhuberant granulations may come from raw surfaces which are not involved in malignant disease, when situated at the orifice of the uterus they should invariably be regarded with suspicion. Many cases have come to my notice about which the attending physicians were in doubt, in which the uterine canal has been so destroyed by the cancerous disease that it has been impossible to entirely scrape away the fragile growths wthout penetrating through the uterine wall into the peritoneal cavity. It is easy to diagnosticate these conditions by curettement under anaesthesia, but the operator should be prepared, in case his fears are confirmed, to perform hysterectomy.

It is impossible to enumerate all the phases of malignant disease as they appear in different localities. The ability to diagnosticate them will depend upon the thoroughness with which the physician studies them in the various organs and tissues. It is impossible to acquire great skill in their diagnosis without having the opportunity to study many cases, for in this as in all other branches of medicine, facility comes with practice. There are many cases in which the best skill will fail to give certainty, and the surgeon is then obliged to make exploratory operations for purposes of diagnosis. As for the practitioner who is in doubt, he must recognize as urgent, the duty of sending such patients, with all speed, to the man who has had a large special experience in this class of cases.

GENERAL VIBRATORY MASSAGE.

By CARL SANDZEN, A. M., M. D.,
Kansas City, Mo.

General massage as a therapeutic agent has not been known very long in our country. The first physician who fully understood and proclaimed its great value was Weir Mitchell, who has shown how in so-called forced feeding or in any kind of abundant nutrition the body cannot receive the full benefit from the treatment without general massage. He tried it with success and other physicians have followed his teachings with the same good results.

One condition that should not be overlooked is that general massage ought to be properly given, otherwise its value is very small. Every physician who has worked along this line has certainly had many discouraging experiences in his dealings with poorly educated, ignorant masseurs and masseuses. This has led to the use of mechanical devices for the application of general massage. I do not need to repeat here how and why vibrations can give sufficient exercise. We accept it as a given fact. The only purpose of this article is to explain how it should be given to get the best results. The time for treatment must be chosen to suit different cases with which we have to deal, e. g., in a case of insomnia, give the treatment as late in the day as possible. If given only as exercise, however, as a substitute for walking, riding, etc., I consider the morning the best time.

The patient should be dressed in underclothing only, with the shoes removed,

A soft union-suit is the best dress of all. Place the patient in a recumbent position on an operating table or chair, if the massage is given in the physicians' office, otherwise on any suitable table or couch. The head should be slightly elevated with a pillow, the legs bent at the knee joints, with the feet somewhat apart and the whole sole placed on a support. This position is the best on account of the relaxation it gives to the muscles of the abdomen and the extremities. All massage movements should be given from the periphery to the center, viz, the heart. Every treatment in general massage ought, therefore, to begin with the feet or hands, usually the feet. Move the vibratode with increasing pressure on the foot from toe to heel or on the hand from the finger-ends to the thenar eminence. Proceed to the calf of the leg and thereafter to the thigh, or, if you choose, treat the upper extremities first, giving to the stroke the length of the whole arm. After the extremities, comes the treatment of the abdomen. Begin the treatment on the right side, somewhat below the cecal region, going upward along the colon ascendens, then following the colon transversum, and at last, colon descendens and flexura sigmoidea. Begin every course anew over the point of exit and finish with vibration from side to side across the abdomen with the purpose of stimplating the small intestines. About five minutes is enough for the abdomen in general massage. Vibrate on the chest either from side to side or up and down.

When the front side is finished, turn the patient on his stomach and treat the back. Move the applicator up and down on each side, up the spine, and from the middle line to the posterior axillary line on each side. On the gluteal muscles, one should use very powerful vibrations and should move the vibratode in the direction of the different muscle-layers, using a good deal of pressure. This constitutes what we call a general treatment, as we never include the head, except in special cases which require vibrations on the head or neck.

No séance should last over twenty minutes, or, at the most, twenty-five minutes, the time being divided according to the operator's best judgment. Large muscle groups require larger and more powerful treatment than smaller ones, etc.

General massage should be given every day if possible, otherwise at least every other day. It is very convenient to have two vibrators, one on each side of the operating table, as it saves a good deal of trouble in turning your patient or moving the apparatus. It is also very good economy to use two machines, as excessive use will destroy (by running hot, etc.,) even the best apparatus.

Kansas City, Mo.

FACIAL ERYSIPELAS.*

G. W. SPOHN, M. D.,
President of the Northern Tri-State Medical Association.
Elkhart, Indiana.

This is an acute contagious disease. In its uncomplicated form, it is a simple inflammation of the skin. It is a surface process and has no tendency towards deeper structures. It is caused by the streptococcus erysipelatis, which does not enter the blood vessels, but follows the lymphatic channels. In the phlegmonous and gangrenous forms the cocci enter the subcutaneous and fatty tissues.

Erysipelas is an unexpected disease. The patient being under general or local treatment, there is no thought of erysipe-

*Read before the Elkhart Co. MedicalSociety.

las, either by the patient or the physician, until the scarlet red color appears.

Experiments have proven, conclusively, that the cause of the disease is the streptococcus. Osler says, "They grow in long chains and are included under the group name of S. pyogenes; with which the S. erysipelatis appears to be identical." The microbes will not attack the normal skin or mucous membrane. The epithelial layer must be broken before they can enter. Any cut, abrasion, or erosion could form a seat for the cocci.

Epidemics of erysipelas, as found a number of years ago, are rare in this age of asepsis and antisepsis. The careful surgeon, seldom has a case; it is the general physician who comes in contact with them but almost universally located in the face.

Writers speak of phlegmonous and gangrenous erysipelas; of idiopathic erysipelas; of erysipeloid, etc. Knowing the microbe that causes the disease, there can be but one kind of erysipelas. The above conditions are only different degrees of the same disease. In the so-called phlegmonous and gangrenous forms, there is a mixed infection, which would be a complication, but no new disease. Typhoid fever may be complicated with pneumonia, but it would not cause a new disease; yet, the system would be obliged to combat the microbes of both diseases and their toxines.

Erysipelas begins with some focus—an ulcer, abrasion, or a fissure at the angle of the mouth, at the alae of the nose, on the septum of the nose, and occasionally at the ear. It is marked by a bright redness, a swelling, a glossy color of the skin, and has the sensation of stretching and burning. The tendency is to spread rapidly. When the inflammation is extensive blisters form on the skin; but nothing serious will result therefrom if they are carefully treated with soothing antiseptics. If neglected, there is a liability of becoming infected with other microbes.

The onset of the disease is often characterized with a chill, and fcllowed with a high fever, rapid pulse, nausea, vomiting, intense headache and general *malaise*. An extremely high and persistent fever, is generally followed with delirium and sometimes with coma.

The cocci are found mostly in the lymph spaces beyond the red border of the parts involved. It is here that an active war-fare goes on between the cocci and the leucocytes.

Kyle says, "the disease frequently extends to the membranes of the brain." This seems to be the opinion of many physicians. While Butler says, "Actual meningitis, as proven by autopsy, rarely occurs, the meningeal symptoms (delirium and coma) arise from the high fever and the toxemia." This is the opinion of many writers.

It is suprising how little is written upon facial erysipelas, and the small differences of opinion by the various authors. In order that I could get the per cent. of facial erysipelas, I sent out a series of circulating letters to physicians, asking them the whole number of cases of facial erysipelas they have had in their practice.

I also asked them to state the point where the disease began. The reports could not be exactly accurate, yet their statements were approximately correct. I feel very grateful to the physicians for their kind assistance. They made it possible for me to prove many of my assertions. Out of one thousand cases reported, nine hundred were facial erysipelas. Of the facial, the beginning point of the disease, was three of scalp, three cheek-bones, seven of the eyes, sixty of the ears, ninety of the mouth, and of the nose seven hundred thirty-seven. This shows that not only ninety per cent. were facial, but also, that about eighty-two per cent. began at

the nose. A careful examination will usually reveal that many of those cases that began over the malar bone, and around the mouth and the eyes are due to some infection, that was carried from the nose by the lymphatic vessels to the focal point.

Why does the face have erysipelas more frequently than any other part of the integument? It is true that the general system must be below the normal point, before microbes can propogate themselves to any extent; the reduction of red corpuscles and haemoglobin,—or any lowering of the vitality will aid the parasitic action, and reduce the saprophitic power of the cells. But this applies equally to all parts of the body. Other parts of the skin are scratched and injured as much, if not more, than the face. Is the face more susceptible to erysipelas, or is there a physical and pathological state that is not understood? The streptococcus follows the lymphatic channels; are there more lymphvessels in and around the nose than elsewhere in the integument? Or is the nose not so aseptic as other parts of the skin and mucus membrane?

A careful examination will reveal to the attending physician, that all or nearly all cases of facial erysipelas unless traumatic, had a previous chronic catarrh, and a partial or total stenosis of one of the nostrils. This is especially true of those cases with the nose as the beginning point of the disease. Many cases have ulcers of the septum, unknown to the patients,—these become infected with the streptococcus, and from them the disease spreads. In many cases the discharge from the nose becomes foul. The catarrhal secretions are often so acrid in their nature that fissures form at the angle of the nose, and the epithelial layer becomes completely denuded. This lowers the vitality of the system, because it is a drain of the serum and leucocytes through the mucous membranes, thus depleting the blood of some of its essential parts. It also forms a fertile field for bacteria, and the eroded mucus membrane opens the way where the streptococcus can enter. However, not all wounds and abrasions, in which can be found S. pyogones develop into erysipelas. There is something lacking in this part of the germ theory that bacteriologists have not been able to clean up.

The prognosis of facial erysipelas is generally good; it depends largely upon the vitality of the patient. The prognosis is unfavorable with small children, the debilitated and the aged. The mortality ranges from four to five per cent. Pneumonia, ulcerative endocarditis, septicemia or albuminuria, are sometimes complications.

In the treatment of facial erysipelas, patients have been abused, mistreated, or overtreated about as much as in the treatment of diptheria. Painting the parts with iodine, the injection of carbolic acid and iodine, etc., into the affected parts has been abandoned. Any medicine injected or applied that would kill the S. erysipelatis would also destroy the tissue, which would be a greater injury by far, than the disease could produce. Various medicines are often applied to dissolve the fat in the sebaceous glands, but this is no benefit. Any mild antiseptic solution that will give comfort to the patient can be applied. Ichthyol in one or two per cent. solution is used much, and has been satisfactory to many physicians. In the treatment of thirty cases, I have tried ichthyol, collodion, iodine, carbolic acid, and many others, but none were so satisfactory as the local application of a solution of bichloride of mercury. In the simple or mild cases, I prescribe the strength of one to five thousand and in the gangrenous form one to two thousand. This should be kept on continuously and as hot as the patient can endure, with cotton or cloths

rung out of the solution. The patient will soon express a feeling of comfort from the hot applications. If blebs form, as is usual, the corrosive sublimate is a good antiseptic to prevent the infection by other bacteria. There is but little danger in the disease if mixed infection can be avoided. The applications should extend three or four inches beyond the red border line, where the streptococci are found most numerous. The heat from the applications aids the circulation; it increases the leucocytes in that region; it stimulates the blood vessels and increases the flow of lymph; and in this way the debris of the microbes is carried away. It is only by phagocytosis that the disease can be overcome. Nature brings on her forces in the various kinds of leucocytes, or blood cells. The warfare goes on between the phagocytes and the streptococcus pyogenes until the former has devoured all the pyogenic microbes. In other words, as soon as nature has regained herself, the facial erysipelas will subside, irrespective of any local applications.

Over eighty per cent. of facial erysipelas begins at the nose. In all cases, the nares should be carefully examined, and treated accordingly. If there are ulcers, they should be touched with a ninety-five per cent. solution of carbolic acid once each day. The nares should be irrigated with a weak solution of carbolic acid or formaldehyde, three times daily, and followed with an antiseptic oilspray. If nasal breathing is difficult, a mentholic oil spray should be used every three to six hours. The nose should be kept as clean as possible.

A popular fad has spread all over the country to treat patients without any internal medicines. Though this may apply to some diseases, it will not apply to the best treatment for facial erysipelas. As stated before, the vitality of the patient must be lowered before he can contract the disease. When the physician is called to a case of facial erysipelas, he should locate the focal point of the disease, and treat it locally; then he should see that all the eliminating organs are working properly; the high temperature should be reduced with water; warm sponging will generally keep the fever down; but cold can be used, if necessary, without doing any injury to the patient. Chloral and the bromides are useful in delirium,—but Dover's powder is superior, because of its diaphoretic and sedative action. No medicine should be given, that will interfere with the proper daily movements of the bowels. Quinine and salicylate of soda in small doses, are reconstructive and somewhat antiseptic to the intestines. Calomel and guiacol in one-tenth grain doses, are good antiseptics for the alimentary canal. If there is any great reduction of red corpuscles, iron is indicated,—even if the temperature is high. The organic irons are preferable, because they are more easily assimilated. In the gangrenous forms,—when there has been an absorption of septic matter,ecinacea is a good remedy. The vitality of the patient must be sustained with proper, concentrated, liquid food given often. The case in hand should be treated symptomatically,—always assisting nature and not opposing her. The danger lies in improper and over treatment.

The antitoxine treatment has been employed with some success. Many physicians who have used it,—speak of it very highly, while others have ceased its use.

The treatment of erysipelas of the ears, pharynx, and larynx would be the same as on the face. It becomes a dangerous disease when it enters the larynx or middle ear. Politzer says, "primary erysipelas of the auricle is rare; it is generally an extension of the disease from the face."

The so-called idiopathic, and recurrent cases are usually due to some trouble in the nose or the sinuses.

In conclusion, it must be conceded that the nose is the starting point of nearly all cases of facial erysipelas unless traumatic. If physicians would advise their patrons that the nose should be kept clean in health as well as in disease, there would be fewer cases. Most children and many adults do not know how to blow their noses properly; and many more do not know how to breathe properly.

The Schneiderian membrane in a catarrhal state becomes a fertile field for bacteria. It impregnates the air taken to the lungs with microbes and depletes it of oxygen. In its normal state, the mucus membrane arrests bactoria, foreign substances, and mitigates all disagreeable oders. It filters, moistens, and warms the air before entering the lungs. He who wants proper oxygenated air in his lungs, must learn to breathe correctly through his nose, and not through the mouth.

The history of facial erysipelas, the cause of the disease, and the beginning point of so large a per cent., should be a plea to every physician to urge of his patients—open and free nostrils—proper breathing—cleanliness of the nares.

DEFORMITIES OF THE FEET CORRECTED BY ELASTIC SCREW AND SOLID PRESSURE.

VINE LA RUE SMITH, M. D.,
Detroit, Mich.

The common method of correcting malformation of the foot is manipulation of the deformed member until all shortened and contracted ligaments and tendons are stretched as nearly as possible to their normal length, then encasing the foot in a plaster of paris jacket or cast. If the patient is young, this may be done without the use of an anæsthetic but on older ones, an anæesthetic is always used. If this does not suffice, the tendon at the heel and the plantar fascia are cut and then the cast is used.

If this is found inadequate, a bony operation is performed; usually that known as the "open method" is used, and then the usual plaster cast applied. If this does not cure the deformity, an amputation is many times considered.

My idea in bringing these cases before the profession, is to show that a clubbed foot under twenty-five years can be made straight without the use of an anæesthetic, tenotomies, open operation or casts in a very short space of time.

This is done with a system of pressure, elastic screw and solid. Braces have been made use of to support clubbed feet for many years, but these braces have been heavy and clumsy. They were in many instances intended to correct the deformity, but they only supported the deformed member or held it in its old position. By the method here illustrated, these pressures are applied very simply, and the apparatus is not intended to be worn constantly. The appliance is made in such a way that the foot comes to it, not like the old one when the brace would twist with the foot.

The first elastic and solid pressure is obtained by two steel bars, one on the outside and one on the inside of the leg, connected by two steel bands; the outside bar is six inches longer than the inside one, and on this bar is placed a pad for solid pressure and at the end is an elastic toe strap which passes over the foot and by this strap, the foot is turned out as far as you wish it to be. The up-

per part of the appliance is made to hold the lower part in the position wanted; this consists of two bars passing from the knee to the upper third of femur, the knee being fixed at right angles; thus placing the extension muscles, thestrong-

Case 1.

est muscles of the lower limb, at rest. After you have obtained the position desired by this method, the foot is ready for the second appliance. The desired position is often obtained in three weeks.

The second appliance consists of two steel bars passing from the knee to the ankle connected by two bands to hold them together, and two bars passing from knee to the upper third of femur to hold appliance in position, the knee being fixed at right angles. To the outside bar is fastened a steel sandal; on this sandal, I get my pressure, solid at the inside of heel, a counter screw pressure over the callous or outside side of the foot, and an elastic counter pressure over great toe.

The foot is held in this position and then brought to the extended position desired in from four to six weeks by an elastic strap fastened to toe of sandal and outer bar of appliance, when an ordinary store shoe can be worn.

Case 1.

The results which have been obtained by this method justify, I think, its introduction to the profession by means of cases treated. It is my desire to report the following two cases taken somewhat at random from a number of others.

Case 1. Hugh F., aged two years, of Utica, Mich., talipes equinus varus, was brought by his mother for treatment July 21, 1904. She gave the history, congenital clubbed feet. At six months, two operations on each foot were performed, one at the heel and the open method on inside, which shows scars from the long incisions. The after-treatment was by casts, several being used. The case was treated this time by the apparatus above described. The time of the second picture was September 29th, 1904. At this time, the patient was walking.

Case 2. John K., aged seven years, of Ecorse, Mich., was brought for treatment August 12th, 1904. Gave the history of congenital clubbed feet. Operated on at one year of age. Teneotomy at heel, plantar fascia cut, and several plaster casts applied; foot turned back after casts were removed. This case was also treated by me with the above described apparatus. Second picture taken October 27th, 1904. The muscles at the calf which are always atrophied in clubbed feet, began to develop as soon as the appliances were put on, so much so that the parents noticed the development at the end of three weeks treatment.

Case 2.

It will be observed that the left leg in this case is short. This is due to the difference in length of femorae, also a congenital defect. The father stated that it was growing in strength with the other limb.

57 W. Fort St.

Case 2.

TRANSACTIONS OF SOCIETIES

The Northern Tri-State Medical Association.

The Northern Tri-State Medical Association held its thirty-first semi-annual meeting at The Zenobia, at Toledo, O., on Tuesday, Jan. 10, 1905. The meeting was called to order by President G. W. Spohn, of Elkhart, Ind., with an attendance of thirty-five members and guests. Minutes of the previous session were read and approved.

A paper on *"Accidental Surgical Cases"* was presented by Dr. A. W. Chase, of Adrian, Mich. In discussion Dr. W. F. Shumaker, of Butler, Ind., said he thought many failures were due to unnecessary washing of wounds with antiseptics, picking out foreign bodies like cinders, etc., and frequent changing of dressings, and branded such measures as "meddlesome surgery." Dr. Frank Broughton, of Waterloo, Ind., did not

agree with essayist and thought antiseptic powder acted as a foreign substance and caused much irritation. He believed in washing wounds with solutions of bichloride, carbolic acid, or lysol. While we cannot destroy all bacteria, we can destroy some, being careful not to injure the tissues. He thought as much foreign matter as possible should be removed from wounds. Where workmen are injured he sometimes used coal oil to remove grease, etc.—Dr. Harpster, of Toledo, reported a case of thumb injury where good results in saving the stump brought curses on him by the patient, for the reason that by virtue of the usefulness of the stump, he could secure no benefit from the company in which he had accident insurance.—Dr. Chase closed the discussion, giving his opinion, that if powders were properly used in properly selected cases, you woud get the best results, in preference to washes.

Dr. Robert S. Walker, of Toledo, O., read the next paper on *"Errors in Treating Syphilis and How to Correct Them."* This paper was published in the February number of THE JOURNAL. —Dr. Shumaker discussed the paper and raised the point of mixed treatment in the second stage.—Dr. J. North thought mercury was the best, but not the only drug we have. Good results are obtained from iodide of mercury because it keeps the mercury in solution. Potassium iodide has little or no effect when mercury has not been previously administered. —Dr. Budd Van Sweringen also discussed the paper.—Dr. Walker closed. He doesn't give iodides in the second stage except in cases of exacerbations Iodine does not control the disease but merely aids in elimination.

"Surgery of Gastric Ulcer" was the subject of the next paper, read by Dr. Julius H. Jacobson, Toledo, O.—Dr. Chas. E. Eisenbeiss, of Elkhart, agreed with the essayist, that all cases of gastric ulcer should be operated as soon as diagnosed.—Dr. Rosenthal, of Toledo, thought prompt surgical intervention of ulcer would lessen occurrence of gastric carcinoma. The operation is not attended with more danger than many other abdominal operations, and can be performed quickly. The dangers are shock, leakage, vicious circle and hemorrhages. The site of anastomosis should be from posterior surface of the stomach to a point in the duodenum ten inches from the pylorus. The colic omentum should be stitched to the stomach to insure firm anchorage of the parts.—Dr. Lewis A. Levison, of Toledo, thought cases of recurrent and chronic ulcer should be operated. The symptom of hyper-chlorhydria is not considered of so much value as formerly, occurring in only 17 per cent. of cases. Peptic ulcers are sometimes a sequal to operation. Dr. Theo. A. Mc Graw, of Detroit, said that in his experience, gastric ulcer and perforation may be simulated by acute pancreatitis and cited a case in illustration. Cases of hemorrhage of the stomach should not always be operated, but treated expectantly with adrenalin and astringents. He thought the statistics of high mortality in operated cases were due to delay in diagnosis and especially operation.—Dr. Smith, of Toledo, did not always find gastric ulcer so easily recognized. Cases of small perforations without leakage do not present pronounced classical symptoms; he ilustrated by citing cases. Dr. Budd Van Sweringen, of Ft. Wayne, thought it was very difficult to make a diagnosis of malignancy in the stomach. One does not always know what one will find on gastrotomy.—Dr. J. C. Fleming, of Elkhart, cited several cases of recovery in hemorrhage of the stomach where the expectant plan of treatment had been pursued.—Dr. Mc Graw agreed that obstruction of pylorus was easy of diagnosis, but not so with cancer.—Dr. Johnson closed by answering Dr. Levison's point of objection with the statement that peptic ulcers rarely

occur in posterior-enterostomy, but are very liable to occur in the anterior operation.

This concluded the morning program, and the Association adjourned until 1:30 p. m., after the following committees were appointed:

Finance Committee:
John North, Toledo, O.
I. J. Becknell, Goshen, Ind.
A. W. Crane, Kalamazoo, Mich.

Membership Committee:
W. F. Shumaker, Butler, Ind.
E. T. Morden, Adrian, Mich.
W. J. Gillett, Toledo, O.
James A. Duncan, Toledo, O.

Board of Censors:
Bud Van Sweringen, Ft. Wayne, Ind.
J. C. Fleming, Elkhart, Ind.
J. H. Jacobson, Toledo, O.

The afternoon session opened with a paper on *"Some of the Clinical Results of High Frequency Currents,"* by Dr A. W. Crane, of Kalamazoo. Dr. Crane not only cited his clinical cases, but described and exhibited a practical and cheap apparatus for the production of a high frequency current for use with an electric lighting current. In the discussion some doubt was expressed about the value of these treatments. In closing Dr. Crane said the reason why others had failed was often because of poor apparatus. He stated that no static machine made furnished enough power to produce clinical results from high frequency currents.

Dr. B. R. Shurly's paper on *"How Shall the General Practitioner Treat Diseases of the Nose and Throat,"* will be published in a later number of THE JOURNAL.

"The Pathology of Gout" was treated by Dr. G. W. McCoskey, of Ft. Wayne, Ind. He went rather fully into the chemistry of the deposits in gout, discussed the relation of the purin bodies to the disease, and the uric acid theory.

The paper by Dr. Theo. A. McGraw, of Detroit, on *"The Local Manifestations of Cancer and Sarcoma,"* is published in this issue of THE JOURNAL.

Dr. K. K. Wheelock, of Ft. Wayne, read *"The Border Line of Ophthalmology to General Medicine."* This will also appear later in THE JOURNAL.

Dr. Dudley P. Allen, of Cleveland, did not read a paper, but gave an interesting account of an operation which he is perfecting for the treatment of depressed fractures of the skull.

The meeting concluded with a banquet at the St. Charles Hotel, Dr. G. Frank Lydston, of Chicago, acting as toastmaster.

E. F. Morden, Secretary.

First Councillor District Medical Society.

The first annual meeting of the First Councillor District Medical Society was held in Harmonie Hall, Detroit, on Febuary 20th, 1905. This district of the State Medical Society includes the counties of Wayne, Washtenaw, Macomb, Oakland, Lenawee, and Monroe. It includes over one-fourth of the entire membership of the Michigan State Society. The total number of registered physicians in these counties is 1,165, of whom 543 belong to the association.

The first annual meeting was certainly auspicious of good ones to follow. Coming in the busiest season of the doctor's year, the attendance and interest was of the sort to insure a profitable meeting anywhere. There was the utmost good feeling on every hand; the discussions were full, frank and occasionally even decidedly warm—in fact, very healthy and vigorous.

The program opened with an address by Dr. Leartus Connor, Councilor of the First District, on the general subject of organization and this branch in particular. It was a most convincing statement of the need of the best interests of the profession to organize for their own good, and was afterward referred to during the day in an appreciative manner. Dr. Mann in the evening going so far as to say that if the Russian government could get the service of Dr. Connor to organize the Zemsty Sabos, its internal troubles could soon be solved. Dr. C. T. Southworth, of Monroe, was chosen chairman, Dr. G. L. Connor, secretary.

The medical part of the program began with a symposium on *Croupous Pneumonia*, as follows:

a—Diagnosis and Treatment in Children —Dr. Charles Goodwin Jennings, Detroit.

b—Diagnosis and Treatment in the Adult —Dr. George Duffield, Detroit.

c—Complications and Sequelae — Dr. S. G. Miner, Detroit.

Dr. Jennings's paper will be published in THE JOURNAL.

Dr. George Dock, of Ann Arbor, opened the discussion and wished to record himself as agreeing entirely with Dr. Jennings' plan of treatment by scrupulous care of the hygienic surroundings, and a minimum of local treatment and drugs. Dr. Flinterman discussed the use of drugs, protesting against their routine and indiscriminate use. He thought that now if less strychnine was used, fewer deaths would result. Dr. Amberg referred to the occurrence of ear symptoms in connection with this disease.

Dr. George P. Raynale, of Birmingham, showed a patient on whom the operation of gastro-enterostomy had been done for pyloric stenosis of supposed malignant character. The patient is now in good health.

The papers presented at the afternoon session were as follows:

"Pathological Fatigue and its Treatment," Dr. I. H. Neff, Pontiac.

"Appendicitis"—

a—"Differential Diagnosis with Reference to Atypical Cases," Dr. W. F. Metcalf, Detroit.

b—"Conservative Treatment with Special Reference to the Starvation Treatment," Dr. J. H. Carstens, Detroit.

c—"Technique of Operative Treatment," Dr. H. C. Wyman, Detroit.

"Leucocytosis in Purulent Processes," Dr. Joseph Sill, Detroit.

"Experimental and Critical Studies of Clay-mixture Poultices," Dr. A. H. Roth, Ann Arbor. This paper detailed experiments with various kinds of poultices, especially concerning the points about which certain advertisers have laid great stress on the superiority of their clay mixtures. The results showed conclusively that none of the highly advertised and recommended substances possess any therapeutic advantage over the old-fashioned flaxseed poultice. The discussion was very spirited and the practice of using and recommending proprietary remedies in general without accurate knowledge of their composition and actual effects was deplored.

It was decided that the officers of the Society should be each year the officers of the regular organization in the county entertaining the annual meeting. The next meeting will be held in Ann Arbor in December, 1905.

A dinner served to 140, concluded the meeting. Dr. Guy L. Kiefer acted as toastmaster, and the following gentlemen responded: Dr. Haughey, of Battle Creek; Dr. Cronin, of Mt. Clemens; Dr. Tibbals, of Detroit; Dr. Loree, of Ann Arbor; Dr. Chase, of Adrian; Dr. Mann, of Detroit. The total registration was 152.

Wayne County Medical Society.

FEBRUARY PROGRAM.

Feb. 6th—*Treatment of Tuberculosis,* by Dr. J. Vernon White. Discussion: Dr. B. R. Shurly, Dr. H. J. Hartz.

Feb. 13th—*Gall-Stones and Digestive Disturbances,* by Dr. L. Breisacher.

Examination of the Feces after Schmidt's Test-Meal and its Value in the Diagnosis and Treatment of Diseases of the Intestines, by Dr. C. D. Aaron. Discussion: Dr. W. M. Harvey, Dr. A. H. Steinbrecher.

Feb. 27th—*The Differential Diagnosis and Treatment of the Chronic Non-tubercular Joint Diseases.* Illustrated by stereopticon. By Dr. W. E. Blodgett. This paper will be published in THE JOURNAL.

The opthalmologists of Detroit were entertained at dinner at the Ste. Clair Hotel on Tuesday, March 7th, by Dr. Fleming Carrow. An historical paper paper was read by Dr Carrow on "The Education of the Blind."

Dr. V. C. Vaughn, of Ann Arbor, addressed a public meeting in Grand Rapids on March 1st, on tuberculosis, and an anti-tuberculosis society was formed there at that time.

DETROIT MEDICAL JOURNAL

A MONTHLY EPITOME OF PRACTICE AND THERAPEUTICS

HERBERT M. RICH, M. D., Managing Editor

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Additions to Our Staff.

With pleasure THE JOURNAL introduces to its readers two new collaborators, Dr. Preston M. Hickey and Dr. Burt Russel Shurly, both of Detroit. Dr. Hickey will deal especially with radiography and will record for us all important advances made in this rapidly developing field of diagnosis and therapeutics. Dr. Shurly will review for us work on the nose, throat, and chest.

Both of these men have achieved distinction in this respective fields, and constitute a valuable addition to the staff of THE JOURNAL.

The Annals of Surgery.

The December number of this publication in commemoration of the completion of its twentieth year, contains upwards of 250 pages of original matter contributed by some of the best known surgeons of the world. It is a matter of some interest that during the entire period of its existence as the only journal in the English language devoted exclusively to the science and practice of surgery, it has had the masterly editorial guidance of Dr. Lewis Stephen Pilcher. To his ability and untiring energy *The Annals of Surgery* will testify long years after he has laid down his pen. Would that every medical editor could leave behind him such a monument! The past twenty years have witnessed not the birth but the development and perfection of surgery and the Annals has been contemporaneous with its great progress with which American surgeons have well kept pace and often led.

Surgical skill is no longer limited to a few great centres but all over the world are found men even in the small cities who, equipped with hospital training, aseptic technique, and pathological knowledge will have thir part in their part in the surgical progress of the future.

To the casual observer it might appear that surgery has reached its highest limit. It is true that every organ of the body has been touched by the surgeon's knife, but in asepsis, technique, diagnosis, judgment, there is much yet to learn. Operative treatment is now comparatively safe, but can be made safer. Anaesthesia still has its dangers; shock and sepsis are still a menace to life; errors in tecnique still occur.

The greatest progress of the future will, we think, be along the lines of earlier and better diagnosis and a wiser judgment as to when to operate and what to do.

The Portland Convention.

There has probably never been offered to the American Medical Association so attractive an itinerary at so low a price as is given this year in connection with the Portland meeting. The Michigan delegation will go to Chicago via the Wabash; to St. Paul via the Rock Island route, spending one hour in St. Paul. Then over the Canadian Pacific to Bans where lies the Canadian National Park

and a stop of a day will be made here in the heart of the Canadian Rockies. Stops of ten and twelve hours will also be made at Langan and at Glacier; then on to Vancouver via Winnipeg. At Vancouver a boat will be taken down the most beautiful part of Puget Sound, landing at Seattle. Train from here to Portland.

The train will start from Chicago on the evening of July 3rd, and arrive in Portland late on July 10th. About two carloads have already signified their intention of going from Michigan. You should send notice of your intention to go to Dr. F. W. Robbins, Detroit, as soon as possible, in order to obtain proper accommodations. The round trip from Chicago will cost $56.50 and the rate between here and Chicago will probably be one fare for the round trip.

Returning, one may exercise some choice of routes. By paying $11 extra one may even go as far south as Los Angeles and return to Chicago via Santa Fe. But one of the most popular routes which can be taken for the return trip without extra charge, will undoubtedly be through Salt Lake City and Colorado. To do this one leaves Portland on the Oregon Ry. & Navigation Line to Huntington, then to Ogden via Oregon Short Line, and to Denver over the Denver & Rio Grande.

From there one returns the entire distance to Chicago over the magnificent scenic route of the Rock Island. One passes through the Colorado mountains and may stop at Salt Lake City, Glenwood Springs, Colorado Springs, and Denver if it is desired.

The editor has been assured by experienced railroad men that such an opportunity to visit so much of the west at such a price is not likely to be repeated for several years. The particular reason for low rates to the coast this year is of course the Lewis and Clark exposition, which will be in full swing in Portland during the meeting of the Medical Association.

The Tuberculosis Question.

The situation at Lansing prompts THE JOURNAL to once more call attention to the economic necessity for each state to have a suitable sanatorium for tuberculous patients, and to the fact that the immediate future is the proper time to act for those who are interested in seeing such an institution established in Michigan. The legislature is in a favorable mood and the Governor needs only to be convinced that it is needed and desired. A little personal work on the part of the physicians of the state would undoubtedly insure the passing of the bill to establish this institution.

The following conclusions formulated by Dr. Wm. S. Thayer,* associate professor of medicine in Johns Hopkins University, may be stated as now beyond dispute in that part of the profession which is most capable of formulating conclusions on such a subject.

1. Tuberculosis is a disease due to the entrance into the body of a specific microorganism—the tubercle bacillus.

2. The microorganism usually enters the body through the nose or mouth by respiration, through infected food or through wounds of the skin.

3. Some individuals and families seem to be especially predisposed to tuberculosis. The nature of this predisposition is not understood.

4. Tuberculosis prevails especially during early adult life.

5. The bacilli are spread about chiefly by spray emitted by patients suffering with the disease on coughing or speaking and by their expectoration.

6. The most important method of the distribution of the tubercle bacilli is probably promiscuous spitting.

7. Tuberculosis is a preventable disease.

8. The most important preventive measures are:

*Report of the Tuberculosis Commission of the State of Maryland, 1 902-1904.

(a) The instruction of the general public and of the sufferers from the disease in the nature of the affection and in the simple and necessary hygienic measures which should be carried out in their abodes as well as the eventual empowerment of the state and city health authorities to insist that the more important of these measures be carried out.

(b The enactment and enforcement of proper anti-spitting ordinances.

(c) The compulsory notification of the city and state health authorities of the existence of every case of tuberculosis.

(d) The introduction and enforcement of proper methods of disinfection of premises vacated by consumptives.

(e) The establishment of hospitals and sanitaria for the care of advanced cases, as well as cases which from their nature and surroundings may be a source of danger to those about them.

9. Tuberculosis is in many instances a curable disease.

10. The important elements in the treatment are:

(a) Rest.
(b) Food.
(c) Fresh air.

11. The establishment of private sanitaria has yielded most valuable service in the treatment of the disease.

12. The establishment and maintenance by the state, of proper sanitaria for (a) the treatment of early tuberculosis and (b) the care of advanced cases of the disease, will save many lives, and in the end will prove an actual financial benefit to the community.

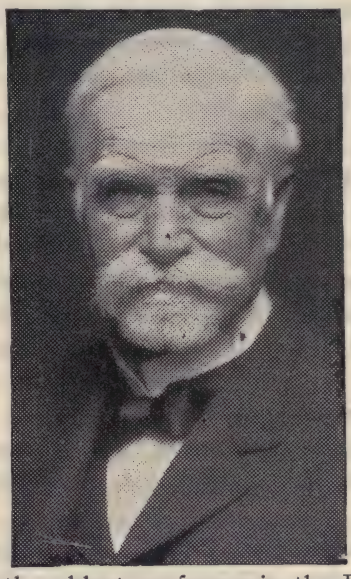
13. There is every reason to believe that though tubercle bacilli may live for certain lengths of time outside of the animal body and may be cultivated on specially prepared media, they flourish only in the living body and that if dissemination of the bacilli from diseased animals and human beings could be prevented, the malady could be arrested.

Convinced of the truth of these conclusions we do not need to say that we heartily endorse every movement to put into force the remedies here suggested.

Dr. H. H. Van Tuyle, of Detroit, has been appointed medical interne at the Ionia State Prison and has begun duty.

Albert Benjamin Prescott, M. D., L. L. D.

The illness of Dr. Prescott, of Ann Arbor, noted in the last number of THE JOURNAL, terminated fatally on February 25th. Dr. Prescott was at the time of his



death the oldest professor in the University of Michigan in point of service, and was 72 years of age. He was professor of organic chemistry, director of the chemical laboratories, and dean of the school of pharmacy. He has stood for many years as one of the best known chemists in this country, being known through his teaching and his text-books on chemical analysis. Much chemical research of great value has been conducted under his direction and encouragement. Few, if any professors in the University have been more generally beloved by their students. Dr. Prescott has served as president of the American Pharmaceutical Association and as president of the American Association for the Advancement of Science.

H. H. Chase, of Linden, Michigan, has received the appointment of botanist for the Panama railroad and will soon leave for Central America where he expects to remain for three years.

EDITORIAL NOTES

FOR SALE.

One of the best equipped offices in the state, situated at Lansing, Mich. Formerly occupied by the late Dr. Winters. Inventory about $1,200—sale price seven hundred and fifty dollars. Address Hardy Bros., Lansing, Mich.

Dr. W. E. Bressey, a familiar figure in Grand Rapids, died on Feb. 18th from a carbuncle. He was 88 years old.

Attorney Samuel T. Douglas has been re-appointed a member of the Detroit City Board of Health by Governor Warner.

Formaldehyde in oysters is one result of an investigation as to the cause of a typhoid fever epidemic in Columbus, Ohio.

A portrait of Prof. A. R. Cushny, of Ann Arbor, will be presented to the University of Michigan by the present senior medical class.

The Gillberg Swedish Medical Gymnastic and Massage Institute has been moved from Blodgett Terrace to 14 Adams Avenue W.

A free dispensary has been established on Michigan avenue by Drs. H. W. Longyear and C. Hollister Judd. Further announcement will be made later.

Leprosy has been discovered at Tamarack City, Michigan. The victim is a Finn who has been in this country fifteen years. The diagnosis was made by Dr. C. L. Rompf.

Dr. Geo. P. Raynale, a graduate of the Detroit College of Medicine, is to be married shortly to Miss Edna Brooks, of Cincinnati. Dr. Raynale is now practicing in Birmingham, Mich., where he went after his resignation from the Medical Staff of the Eastern Michigan Medical Asylum of Pontiac.

Two physicians are before the public as nominees for members of the Board of Regents of the University of Michigan. Dr. W. H. Sawyer, of Hillsdale, is the nominee of the Republican party and Dr. Orson Millard, of Flint, has been nominated by the Democrats. Both are graduates of the Medical Department of the University.

Dr. J. Collins Warren retired from active service as surgeon to the Massachusetts General Hospital, in Boston, on January 31st, last. In commemoration of this event, Dr. Warren's house-officers, past and present, presented him with a beautiful punch-bowl suitably inscribed. Dr. Warren has been connected with the hospital for thirty-six years in twenty-nine of which he has had an active service as visiting-surgeon. The recent publication in the *Annals of Surgery* of a series of breast amputations by him for malignant disease is a notable contribution and an illustration of the high point of perfection to which he had brought his art.

Governor Warner has appointed three new members to the Michigan State Board of Health—Dr. Angus McLean, of Detroit, Dr. M. C. Sinclair, of Grand Rapids, and C. C. Vaughan, of St. Johns.

Dr. McLean is a well known surgeon of this city. He graduated from the Detroit College of Medicine in 1886, and has spent some time in study abroad. He has served as city physician and police surgeon and is now surgeon to Harper Hospital and professor of clinical surgery in the Detroit College of Medicine.

Dr. Sinclair is a homœpathic practitioner of Grand Rapids. Mr. Vaughan is an editor, well known through the central part of the state.

RECENT DEATHS.

Arthur Toal, M. D., Detroit College of Medicine, 1887, died at his home in Peck., Mich., Jan. 24th, from angina pectoris, aged 49.

Frank B. Jones, M. D., University of Michigan, 1872, of Petersburg, Mich., died recently.

Dr. John F. Everhardt, one of the oldest physicians in Detroit, has recently died. He had practiced here from 1883 to last summer, and had been a physician over fifty years. He died at the age of 73. Dr. Everhardt came of a distinguished Philadelphia family and was a cousin of Gen. Robert E. Lee.

Dr. F. J. Downer, assistant physician at the Upper Peninsula Asylum for the Insane, dropped dead of heart disease on Feb. 20th, aged 67. He graduated at the University of Michigan and was formerly chief surgeon for the Quincy Mine at Hancock.

Dr. William Jackson died in Climax, Michigan, on Jan. 14, after a short illness. He was over 60 years of age and had practiced medicine in Climax about 25 years.

Dr. Gustave, a graduate of the University of Copenhagen and the Cincinnati Medical College, died at Trufant, Michigan, on Jan. 12th, of hemorrhage from the stomach after three days' illness.

Dr. Humphrey B. Anderson, president of the Grand Traverse Medical Association, died at Traverse City on Feb. 8th, aged 46. He graduated from the Toronto School of Medicine and later attended the Detroit Medical College. He had practiced in Traverse City since 1889.

The Hall of Fame.

Twenty-six names are to be added this year to the Hall of Fame in New York. There is no physician among the twenty-nine names now entered there, and it is not unworthy of the attention of the medical profession of this country to take some steps toward securing recognition there. The importance of the work of the profession is certainly of a sort to merit its inclusion in any such memorial, and it would seem that a certain amount of interest on the part of the profession is all that will be necessary to obtain this. Benjamin Rush, Valentine Mott, and T. Marion Sims, have already been nominated. It is proposed to add to this list John Collins Warren, David Ramsay, and Oliver Wendell Holmes.

A definite movement to this end has been undertaken by Dr. H. Winnett Orr, of Lincoln, Nebraska, editor of the *Western Medical Review*. If physicians interested will write him and enclose twelve cents in stamps, the plan will be explained and put in motion. We are very glad to vouch for Dr. Orr's sincerity and ability and hope many of our readers will be patriotic enough to make the effort for a worthy, if remote cause.

Prophylaxis of Diphtheria in Schools: —Benraugel believes that the usual methods of prophylaxis as practiced in French schools, viz.: disbanding and disinfection of premises, are inefficient and illusory. The mischief of the spread of the disease may very likely have taken place before the school is dismissed; school may be indefinitely postponed and many deaths result. The closing of school is a great economic misfortune. For successful combat of diphtheria now, antitoxin must be used. Every person in the school who has come in contact with the case of diphtheria should receive an immunizing dose. It is the duty of the State to furnish such antitoxin to all schools when necessary, either public or private.—**(These de Paris, 1904.) Archives Generals de Medicine,** Dec. 27, '04.

THERAPEUTIC NOTES

To Avert Boils, Etc.—

An ethereal solution of menthol, 10 to 50 per cent., applied with a camel's hair brush, averts boils, carbuncles and inflammatory gatherings, and cures itching eruptions.—*Ex.*

For Acute Dysentery.—

℞ Tinct. opium.....3iv
Spts. chloroform.....3iv
Aromat. sulphuric acid.....3iv
Syrup lemon, q. s., to make..℥iv

M. Sig.: One teaspoonful every two or three hours.—*Roosevelt Hospital Formulary.*

Excessive or Offensive Perspiration.—

℞ Formaldehyde .....mxxx
Aq. pur.....℥xvi
Ft. Sol. S.—Bathe affected part once or twice a day.

Laryngitis.—

℞ Muriat of cocaine.....gr. xxv
Camphor water.....℥ii

M. Sig.: Use as a spray for throat.

Indications.—To relieve pain in syphilitic, tubercular, or cancerous laryngitis. —*Prescription.*

NEW INSTRUMENTS AND DEVICES

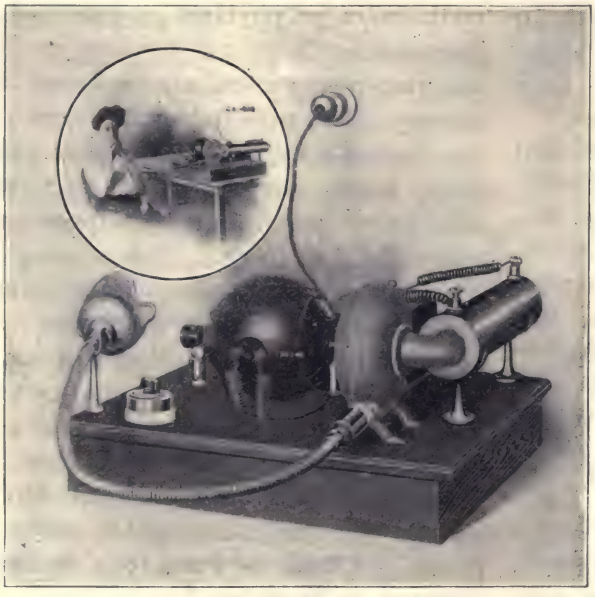
Mention of new instruments and devices in this department is entirely complimentary and articles illustrated are judged on their merits.

We invite manufacturers and physicians to send us matter suitable for publication under this head. A description of the device and an electrotype or half-tone with a base not greater than two and five-eighths inches should be sent.

Always mention the price of the article in question.

The management cannot undertake to return cuts unless postage for same accompanies the letter with which they are sent.

To Our Readers—The Detroit Medical Journal publishes descriptions of such aids to the profession as it knows to be reliable and trustworthy. We shall be pleased to furnish information as to the articles mentioned, or the articles themselves, upon receipt of an inquiry.



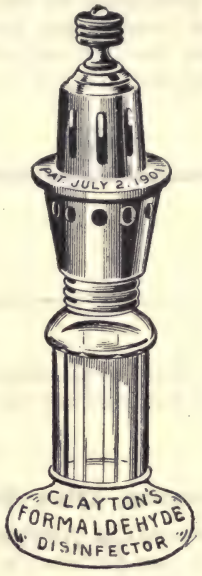
Ozone Generator.

On its mechanical side, the chief feature of this generator consists either of concentric glass tubes, graduated in size and placed one within the other, or of glass plates arranged in layers. The intervening spaces between the tubes or between the plates are filled with terminals for the introduction of the interrupted electric current. These terminals are so constructed that they offer little resistance to the air passing through them, while at the same time filling the space they occupy between the glass surfaces, with the electric effluvia generated by the low tension interrupted

current. With this form of generator there is no air space which the current must cross in its passage from one terminal to another, for a dialectric in the form of glass is interposed, with the terminals resting upon the opposite side of wall for the diffusion of the electric current, thus avoiding the air-gap which in other generators is the source of the poisonous nitrous fumes and oxides which accompany the ozone which they produce. With this generator there is neither heat nor spark, as the action of the dialectrics interposed between the terminals prevents this and tends to keep the temperature of the generator at a normal degree, consequently, the ozone produced is free from impure nitrogen and oxygen compounds and can be inhaled without producing distressing or injurious effects.

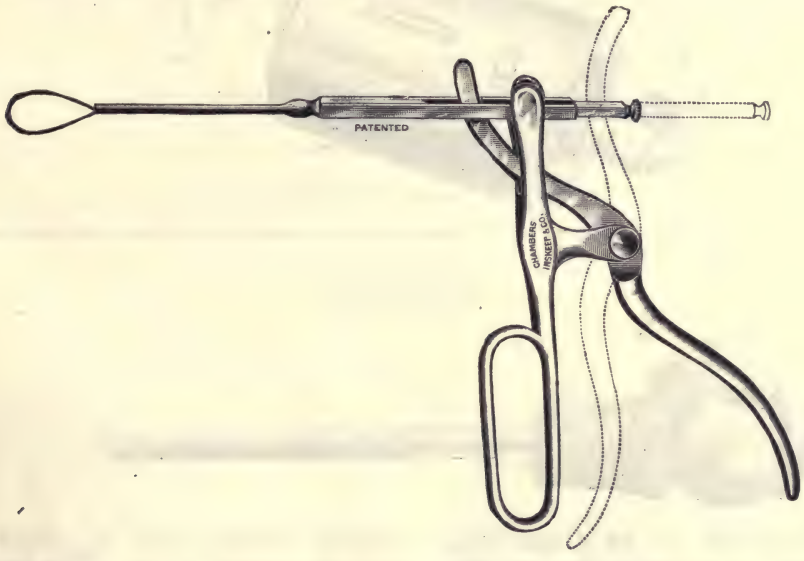
Formaldehyde Disinfector.

This is a small and very convenient instrument for the generation of formaldehyde gas. The gas is produced by the combustion of wood alcohol in the presence of platinized discs. It is small, safe, sure and cheap. There are many uses for such an instrument, beside those strictly medical, as, e. g., destroying moths, mosquitoes, and other insects; deodorizer; purifying a refrigerator; disinfecting clothing, etc. Price, $1.50.



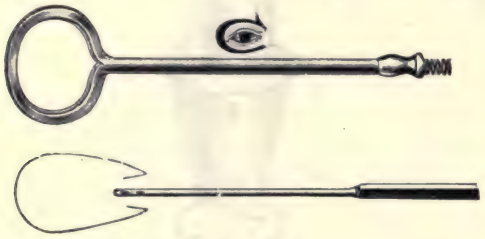
Tonsil Snare.

The tonsil snare here presented is a modification of the snare originally devised by W. H. Peters, M. D., for instant and bloodless tonsillotomy. This instrument is simple in construction and easily manipulated.



By distending the lever hand-piece to

the maximum the stylet is pushed forward until the tip of the stylet (which has two small openings for receiving ends of loop) is presented at the end of the canula. The wire loops, furnished with the snare, are easily attached to the stylet with either the straight canula or Vedder fenestrated tip in position.



By slightly contracting the handles the stylet is now drawn back until the ends of the loop are within the canula. The loop can now be spread and shaped if the straight canula is in use or be adjusted to fit the groove of the Vedder's fenestrated tip.

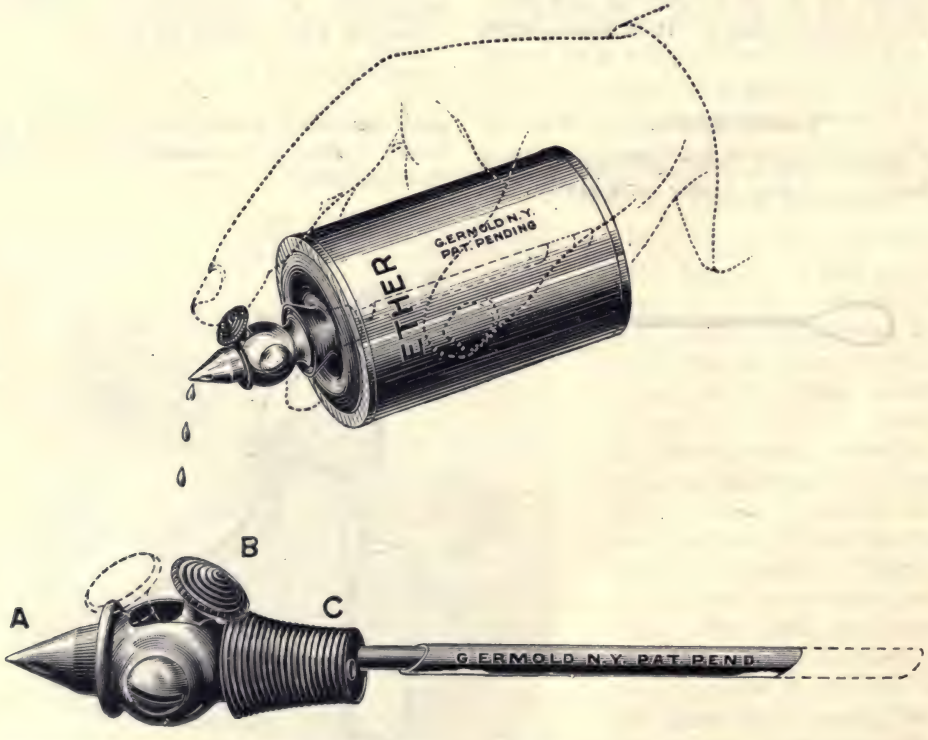
The instrument, now ready for use, is introduced into the mouth, with a pair of forceps the tonsil is drawn through the loop or fenestrated tip and, with a single stroke, the tonsil is severed. The loops are made of such a length that when the handle is contracted the tip of loop is drawn entirely within the canula, thus assuring a complete severing of the tonsil.

The retail price of snare is $10.00 complete with one straight and one middle size Vedder tip and a supply of loops.

Combination Ether Dropper.

This instrument, a combination ether-dropper and can-perforator, is intended to do away with the necessity for a special dropping-bottle for an anaesthetic. Point A is used to perforate the lead seal to the can, the instrument is then reversed and the plug C screwed tight. B is a button for regulating the supply of ether by drops.

It can be used with a glass bottle by slipping a short piece of rubber tubing over the conical screw. The larger cut shows the dropper in use.



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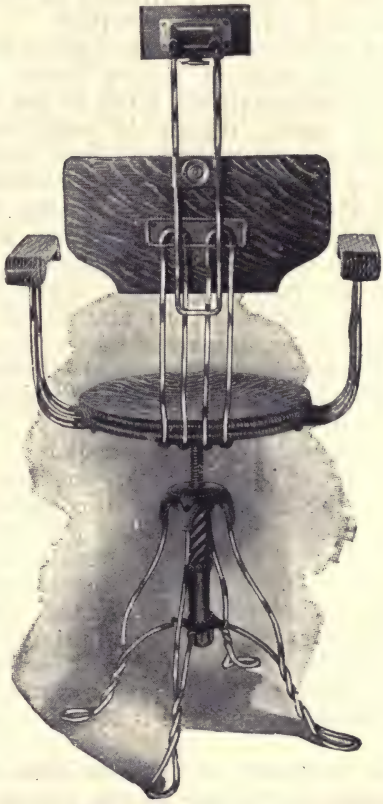

PROGRESS OF MEDICAL SCIENCE

Undescended Testicle.

Odioene and Simmons contribute to the December number of the *Annals of Surgery* a careful study of 77 cases of this abnormality.

It is hard to assign the precise cause of the arrest of the testicle in its normal descent other than some defect in development during embryonic or foetal life.

An undescended testicle may be—

1. Entirely within the abdominal cavity.
2. In the inguinal canal.
3. Just outside the external ring in close relation to the pubic bone.
4. In the extreme upper part of the scrotum.

The inguinal variety is the most common, all types being accompanied with a certain amount of atrophy of the corresponding side of the scrotum.

The undescended testicle gives rise to symptoms incident to its location. A testicle comparatively fixed in the inguinal or pubic region is subjected to traumatism or pressure from without, while a sudden and violent contraction of the abdominal muscles pressing on the testicle in the canal often causes a most painful and severe inflammation. The symptoms may vary from slight sensations of discomfort to attacks of very severe pain accompanied by swelling, extreme tenderness, nausea and vomiting.

An undescended testicle is almost always unperfectly developed and in the great majority of cases incapable of the formation of spermatozoa. Inguinal hernia is the most common complication being present in about 57 per cent. of this series of cases. Hydrocele, torsion of the cord and orchitis are also of frequent occurrence. Malignant disease, especially sarcoma, is very prone to develop in the undescended testicle whether from traumatic irritation, imperfect development or impaired function is uncertain.

The treatment of this condition varies according to the age of the patient, and the severity of symptoms or presence of complications in the given case. In infancy and early childhood, massage and manipulation may aid the descent of the testicle to its normal location. After the age of eleven or twelve the chance for descent of the testicle is very small, and the certainty that this testicle will not undergo the changes incident to puberty will justify operative attempt at transplantation to the scrotum. If the deformity be double no child should reach puberty without the endeavor to bring the organs into normal position and prevent permanent sterility. If but one testicle is affected it may be replaced in the abdomen, removed, or dropped to the scrotum, if the spermatic cord can be so lengthened as to allow it. In the main the outcome of attempts to place the testicle in the scrotum has not been satisfactory; retraction of the testicle with atrophy being the rule, a normal position without impairment of development being the exception.—*F. B. Tibbals.*

Acute Tuberculous Pneumonia.

Under the above title, in the February number of the *Brooklyn Medical Journal,* Dr. Wm. Osler gives a resumé of this disease, quoting from 15 cases in his own experience. Although mindful of the rarity of the condition, he draws attention to its importance, and the suspicion of it which a physician should entertain in any unresolved case of pneumonia. Its onset is sudden and cannot be differentiated from the croupous form; the symptoms and signs are the same during the first week, except that in a few cases early apprehension of tuberculous infection may arise from the presence of a peculiar grass-green sputum. As a rule, however, the true condition is not suspected until delayed resolution leads to bacterial examination, when tubercle bacilli are found in great numbers and an excess of elastic fibres. Leucocytosis is usually high.

The diagnosis being made, the prognosis is grave. The "fulminant" forms terminate in death in eight to twenty-six days; a larger proportion pursue the course of "galloping consumption" and die in eight to ten weeks; a few show an amelioration of symptoms, and enter

upon the "chronic phthisis," with its chance of recovery. "In the majority of cases the course of the disease is downward;" there are the severe sweats, high fever, cough, expectoration, hemorrhage, asthenia, and the physical signs of softening in the lungs.

The disease at its inception may be confused not only with the croupous pneumonia, but also occasionally with typhoid fever. Toxemic symptoms may be extreme, consolidation may be overlooked, and a diazo reaction present. But the absence of the Widal test, negative blood culture, high white count, together with careful routine examination of the chest, will save one the mortification of this error.

As to pathology, the condition is one of extensive caseation, either of one lobe, or of one lung; the other lung is rarely affected. Tubercles are not widespread. Softening is common. Indeed the picture is little different from the chronic lesions, but its rapidity is its distinguishing feature. The origin is probably from the rupture of a small local focus into a bronchus,—the aspiration theory. It has, however, been suggested by careful observers that it is hematogenous.

The disease has occurred oftenest in middle-aged people, and in males; there has usually been no previous symptom of tuberculosis. The writer calls to mind the other two forms of acute pulmonary tuberculosis,—"Miliary," and the "broncho-pneumonic," which are quite distinct from the condition under discussion.

Treatment is usually hopeless. The rare cases that tend to convalesce into a quiescent chronicity should have the accepted hygienic regime. Dr. Osler takes occasion, on concluding his paper, to emphasize the importance of early diagnosis in all tuberculous conditions.—*C. S. Oakman.*

The Mechanical Treatment of Hip Disease.

Adolph Lorenz, *Jour. Am. Med. Ass'n*, Feb. 5, 1905.

The natural history of tubercular hip disease entirely untreated opens with intermittent limping, which after several months becomes constant and is accompanied by increasing pain and disability, on account of which the child cannot leave bed for a period of from a few months to a year. At the end of this time, the child begins to walk again, usually on the fore part of the foot. The end result is marked contracture in flexion and adduction; perhaps ankylosis; perhaps healed or active sinuses, but, as it appears to the author, no oftener than in treated cases. The patient, however, is able to walk without apparatus, the bones are firm and capable of weight-bearing, and the muscles of the limb are comparatively well developed.

The course of the strictly treated case, on the other hand, one treated by extension in bed and by extension ambulatory apparatus, is less painful, and leaves the hip in good position with slight mobility. But the leg itself, due to powerless muscles, relaxed knee, and fragile bones, is "a loose wobbling appendage of the trunk," and, unaided, cannot at expiration of treatment support the body for even a moment.

If we now compare the two cases, we are forced to acknowledge that, in the latter case, the end result of our effort of years is disproportionately small. The only noticeable advantage of this strict mechanical treatment is probably a diminution of the coxitic pain. But this is counterbalanced by the great discomfort occasioned the patient by a narrow, tightly fitting apparatus."

"The course of the disease is not shortened by the strictest mechanical treatment, the frequency of abscess formation is hardly lessened, whereas the leg will unquestionably remain unfit for independent functional use for a much longer time than if the mechanical treatment had never been used at all. Another so-called advantage is the good position obtained, but this prevails only so long as the apparatus is worn. Let the patient discard the same, and he will not often escape the resulting contracture caused by walking.

To avoid the severe atrophy and loosening of the knee that result from entire functional restraint with extension, and yet to secure for the patient relief of pain, continued ability to get into the fresh air, a favorable position of limb, and, if obtainable, a bony ankylosis, which renders the hip less liable to subsequent trauma or contracture than when the hip is slightly mobile, the author's practice is to employ

plaster spicas only to the knee, and to allow this joint and the limb below to functionate and support the body-weight, without extension. When weight-bearing is painful, the lower leg and foot are protected by a leather attachment to the spica, with joints at knee and at ankle, and, in acute cases, the weight is temporarily wholly born by this attachment. In convalescence, a leather spica is substituted, and, if the hip is mobile, in order to prevent adduction-flexion contracture after the apparatus has been permanently removed, massage and active and passive movements in abduction and extension are instituted.

These measures constitute Lorenz's "physiologic mechanical treatment."—*William E. Blodgett.*

Menstruatio Praecox.

T. Lenz reports a carefully observed case of menstruatio praecox which exhibited not only the bleeding but also other signs of sexual maturity in such a way as to present a case almost unique.

The child was then six years and three months old, but looked to be at least thirteen. She was 127 cm. tall (normal 104) and weighed 26.5 kg. (normal-16.5). Born a large child, she grew very rapidly as an infant, and at the age of four months her breasts began to swell and blood appeared on her external genitals. By the sixth month the bleeding was appearing regularly every fourth week, lasting three or four days. This has continued with the exception of one six months' period following attacks of scarlet fever and bronchitis. At the age of eighteen months, hair appeared in the axillae and over the pubes. The whole body, especially the hip region, soon after took on the characteristic mature shape of puberty. The mammae are half-bullet shaped, 14 cm. in diameter; the nipples large, areolae broad and deeply pigmented: the labia majora are pigmented and rich in fat; hymen present. Per rectum one can feel a very slightly enlarged uterus but a large, lobulated left ovary.

The osseus system presents the same signs of maturity. There are no cartilaginous epiphyses to the femorae; the os ilei, ischii, and pubes are already united. The pelvis resembles that of an 18 year old girl. The child seems to have no sexual feelings, does not masturbate, is shy. There are no traces of rickets. Two older sisters are smaller than she.—*Zentralblatt für Gynäkologie.*

The Circumstances and Treatment of Movable Kidney.

Sir Frederick Treves, *Canadian Practitioner and Review.*

The recognition of movable kidney did not become general until well along in the last century. The first sound clinical description was given by Pierre Rayer in 1839. This recent discovery of the condition does not indicate that it is a new lesion,—a "stigma of degeneration,"—but rather that the older practitioners failed to perceive it, or mistook it for other conditions. Pathological statistics reveal only one-seventh of one per cent. of movable kidneys, while Glenard from clinical observations asserts that 22% of all adults are afflicted, of which 87% are females.

The kidney, although normally slightly movable, probably does not make so great a respiratory excursion as 3-5 cm., which is claimed by some. The author is of the opinion that certain strands of condensed tissue, which pass from the posterior abdominal wall to the renal capsule, are important agents in holding the organ in place. The preponderance of the lesion on the right side is notable. Etiology is still in doubt; trauma is surely one factor; the rapid loss of intra-abdominal fat is another; but several causes usually urged are very dubious, such as horseback riding and tight-lacing, while the meso-nephron, so often described, is a myth.

There are four degrees of motility:—1st, the kidney just descends on inspiration. Its lower end can be felt, but not held. 2nd, The kidney can be held between the fingers, but its upper extremity is not to be defined. 3rd, The tissues above the upper end can be compressed and some definition of the upper end be made. 4th, The kidney is floating and may be found far from its place.

In the movement of the kidney from its normal position, its upper end inclines outward and the outer border inclines forward. The diagnosis of movable kidnew is often suggested by symptoms, but should never be made unless anatomical

displacement can be positively demonstrated, and even then the symptoms ought not to be attributed to the kidney until other causes can be with certainty excluded. The severity of symptoms is not in proportion to the degree of mobility; the classic severe manifestations are rare, and the lesser manifold ills are often to be traced to neurasthenia. Riedel's lobe, fecal masses in the colon, and distended gall-bladder, have been mistaken for ren mobilis.

From personal experience and analysis of series of others, the writer has come to believe that surgery is not indicated, unless,—1st, there are torsion symptoms, or 2nd, there are persistent minor manifestations which have resisted all other means of treatment. "The time is not far distant when suturing the kidney will be one of the rare operations of surgery." Good results are obtainable by rest cure, and by a special truss which the writer originated in 1895.—*C. S. Oakman.*

Leucocytosis.

A. Mansfield Holmes, *Jour. Am. Med. Ass.* Jan. 28, 1905, in a paper entitled "The Nature and Significance of Leucocytosis" reviews the various attempts at a classification of the types of leucocytes, and adopts Metchnikoff's (dividing leucocytes into two classes, phagocytic and non-phagocytic) as the basis of his conclusions.

He groups the polymorphonuclears, transitionals, and large lymphocytes as phagoctyes, and the small lymphocytes and eosinophiles as non-phagocytes.

He then discusses the normal variation of the number of these cells in the peripheral circulation. Placing the normal variation in the total leucocyte count in health as 5000—10000, they are divided as follows:

Polymorphonuclears	3000-7000
Transitionals	50- 200
Large Lymphocytes ..	250- 900
Small Lymphocytes....	1100-3000
Eosinophiles	50- 200

He maintains that since the phagocytic cells are also ameboid, the variations in their number in the peripheral circulation are due to their ability to migrate from the deeper organs to the periphery, while this is not the case with the non-phagocytic cells (small lymphocytes and eosinophiles). He concludes therefore that variation in the number of ameboid leucocytes in the peripheral circulation does not necessarily predicate variation in the functional activity of the organs producing them, but that any variation in the number of the non-ameboid cells in the peripheral circulation must be due to such a cause.

He further says that the small lymphocytes being generally conceded to be young cells, and cell genesis being one of the most potent and one of the most important functions of an organism, it is naturally inferred that the state of this function sustains an important relation to the resisting power of the organism.

His conclusions, supported by a series of cases, are that the number of small lymphoctyes in the peripheral blood is a fair index of the resisting power of the patient to an infection; that when the lymphocyte count is high, the resistance is good, and the outlook favorable; that when the lymphoctye count is low, especially when it falls below his normal minimum (1100 per c. m. m.) the resistance is low, and the prognosis bad.—*Joseph Sill, M. D.*

Dr. Osler's Valedictory Address.

The Journal A.M.A. prints in full, March 4, the valedictory address of Dr. Osler, of Johns Hopkins University, which has been quoted and misquoted in the daily press. He deals with some of the problems of university life and states that at times the loss of a professor may be of benefit to a university. He stated that to a man of active mind too long attachment to one college is apt to breed self-satisfaction, to foster a local spirit, and to promote senility. He said that much of the phenomenal success of the Johns Hopkins University has been due to the concentration of a group of intellectual men, without local ties, whose operations were not restricted and who were willing to serve faithfully in whatever field of action they were placed. Dr. Osler advised the interchange of teachers, both national and international, and even advised the changing of college presidents now and then "for the good of the exchequer." He said that intellectual infantilism and progeria were two appalling maladies due to careless habits "of intellectual feeding." As a prophylactic measure he advises vis-

iting other universities and colleges, both at home and abroad. He said that it is a very serious matter to have all the professors in a university growing old at the same time, and said that there should be a fixed period for the teacher, either of time of service or of age. He spoke of the comparative uselessness of men above 40 years of age, and said that to modify an old saying, "A man is sane morally at thirty, rich mentally at forty, wise spiritually at fifty—or never." He said that the young man should be encouraged and afforded every possible chance to show what is in him, and that the chief value of the teacher, who is no longer a productive factor, is to determine whether the thoughts which the young men are bringing to the light are false idols or true and noble ideas. He said that it would be of incalculable benefit, in commercial, political and professional life if men would retire from work at the age of 60. He said that the teacher's life should have three periods, study until 25, investigation until 40, profession until 60, at which age he would have him retired on a double allowance. He went at some length into the history of the Johns Hopkins Medical school, mentioning the strict entrance requirements and the scientific teachings in laboratory work especially. He dwelt on the necessity for practical training in the hospital wards as well as in the laboratories and class rooms. He said that the faculty of Johns Hopkins University has been blessed with two remarkable presidents, who had been a stimulus in every department, and that the good fellowship and harmony among the faculty has been delightful.

BOOK REVIEWS

Pulmonary Tuberculosis: Its Prevention and Cure. By Carlo Ruata, M. D., Professor of Materia Medica in the University of Perugia. Illustrated. Bristol, England: John Wright & Co., 75c.

This little manual on our great medical enemy is a model of its kind in many respects. Written in non-technical language for the general reader, its circulation would do much to spread sound doctrines concerning this much discussed disease. It by no means avoids anatomical and pathological conditions; it does not avoid difficult questions by not mentioning them, but states them carefully and simply. Not all of us will agree that the reason tuberculosis is more prevalent among Italian women than English is because the former wear tighter corsets, but that is an aside. The fresh-air treatment is fully and well described and the credit of its first application to this disease is very properly given to Bodington, who published his "Essay on the Cure of Pulmonary Consumption, on Principles Natural, Rational, and Successful" in 1840, nineteen years before Brehmer opened his sanatorium. As a whole the volume is to be commended as sane and sound.

RECEIVED:

(Grateful acknowledgment of the receipt of the following is hereby made. Further notice in our review column may be given).

Inaugural Address of the President of the New York County Medical Association, Frances J. Quinlan, M. D., LL. D. Reprint.

Summary of the Annual Report of the Library Committee for 1904. College of Physicians of Philadelphia. George C. Harlan, M. D., chairman.

Politics in New Zealand,—selected and arranged parts from the book entitled "The Story of New Zealand," by Frank Parsons and C. F. Taylor. Philadelphia: C. F. Taylor, 1904.

Medical Bibliography. By H. Winnett Orr, M. D., Lincoln, Neb. Reprint.

Who is Your Physician? By H. Winnett Orr, M. D., Lincoln, Neb. Reprint.

Transactions of the Luzerne County Medical Society, 1904. Editor, Dr. Maris Gibson, Wilkesbarre, Penn.

A Plan to Eradicate Syphilis, Chancroids and Gonorrhea. By A. W. Herzog, New York City. Reprint.

A Proctological Clinic. By John L. Jelks, M. D., Memphis, Tenn. Reprint.

Golden Rule Series. 14 volumes. Bristol, England: John Wright & Co.,

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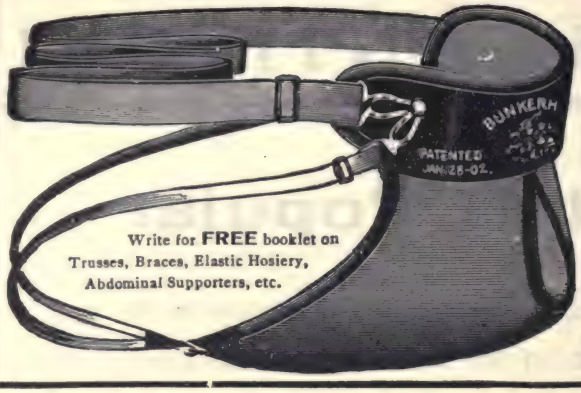

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Preliminary examinations for appointment of Assistant Surgeons in the Army will be held on May 1st and August 1st, 1905, at points to be hereafter designated.

Army Medical Corps.

Permission to appear for examination can be obtained upon application to the Surgeon-General, U. S. Army, Washington, D. C., from whom full information concerning the examination can be procured. The essential requirements to securing an invitation are that the applicant shall be a citizen of the United States, shall be between twenty-two and thirty years of age, a graduate of a medical school legally authorized to confer the degree of doctor of medicine, shall be of good moral character and habits, and shall have had at least one year's hospital training or its equivalent in practice. The examinations will be held concurrently throughout the country at points where boards can be convened. Due consideration will be given to the localities from which applications are received, in order to lessen the traveling expenses of applicants as much as possible.

In order to perfect all necessary arrangements for the examinations of May 1st, applications must be complete and in possession of the Surgeon-General on or before April 1st, and for the examination of August 1st, on or before July 1st. Early attention is therefore enjoined upon all intended applicants.

There are at present twenty vacancies in the Medical Corps of the Army.

Special Directions for the Use of the K. & O. Bermingham Nasal Douche.

One of the objects in the application of Glyco-Thymoline to the nasal cavity is to retain it in direct contact with the membrane for at least two minutes; this can be done very simply and effectively as follows:

Put into the douche one or two teaspoonfuls of Glyco-Thymoline (Kress) filling it with warm water (never use cold). With the index finger over inlet to control the flow, insert the nozzle into the nostril, and hold the head well back, while allowing the solution to run into the nose; breath through the mouth (pant as it were); this closes up the passage into the throat and enables you to fill the entire nasal cavity. As soon as it is full, take the douche away, pinch the nostrils together and throw the head well forward; hold the solution in the nasal cavity for a couple

Do not blow the nose until you have thoroughly co-Thymoline loosens up all the catarrhal crusts. flammation into the eustachian tubes, as the Glyof minutes and repeat in the other nostril. Clear the head gently to avoid forcing products of incleared the nose and throat.

Treatment of Chronic Ulcer of the Leg of Long Standing.

By HORATIO W. A. COWAN, M. B. C. M. (Aberd.)

(From The Lancet, London, Eng., July 2, 1904.)

At the beginning of the present year I was called to a woman, aged 54 years, who had a chronic sloughing ulcer for 22 years, situated on the outside of the left leg, some 10 inches long and three inches wide, with indurated edges and some thrombosis of the veins of the inside of the knee. Having first cleansed the ulcer with charcoal poultices for two days, I applied wet butter-cloth and then spread Antiphlogistine over it, after which cotton wool and a bandage were put on. This was done every day by the patient's friends for four months. The ulcer is now quite healed over, and the induration is all gone. She is able to resume her ordinary housework. I publish this case in the hope that it may be useful to others, as Unna's paste and all sorts of methods had been previously tried. I may say that I have no personal interest in Antiphlogistine.

Painful Menstruation in Virgins.

Dr. Wm. Sellman, of Baltimore, read this paper and pointed out the necessity of giving relief to young unmarried women who suffered from painful menstruation. He considered the forms of dysmenorrhoea that could be relieved by operation. These means should not be of a character to unsex the patient. Lastly he spoke of that class of cases in which dysmenorrhoea was due to a general systemic neuralgia. In these cases, electricity in its different forms afforded great relief. It was doubtful in many of these cases whether the removal of the appendages would accomplish anything more than bring about a premature menopause.

Dr. H. W. Longyear, of Detroit, stated that in operating, if one ovary or a part of an ovary could be saved, he did so. He would enter a protest against operating on cases of dysmenorrhoea that were of short duration in young girls.

Dr. William Humiston, of Cleveland, Ohio, had seen cases with a narrow, conical os, menstruating without the least sign of distress, but the moment an inflammatory condition of the mucosa was added, that moment the patient began to have painful menstruation.

Dr. D. Tod Gillian, Columbus, Ohio, spoke of the undeveloped condition of the uterus as a cause of dysmenorrhoea. It was not the result of stenosis of the internal os, but to an unripe condition of the uterine tissues.—Med. Review of Reviews.

The thing that surprises us most in the above article is that not a single voice was raised to proclaim the almost magical effects of antikamnia tablets in such cases. We can readily recall quite a number of cases in which extreme suffering (dysmenorrhoea) was promptly relieved, not by operation, but by antikamnia tablets. Evidently these men were surgeons only.—Ed. Massachusetts Med. Jour., January, 1905.

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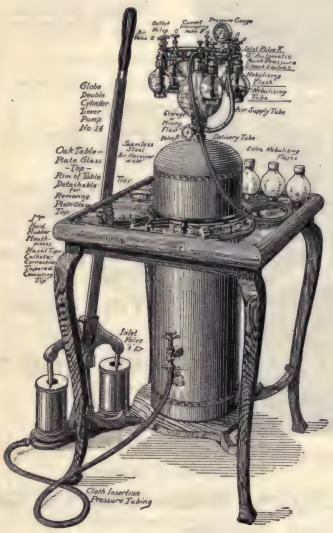

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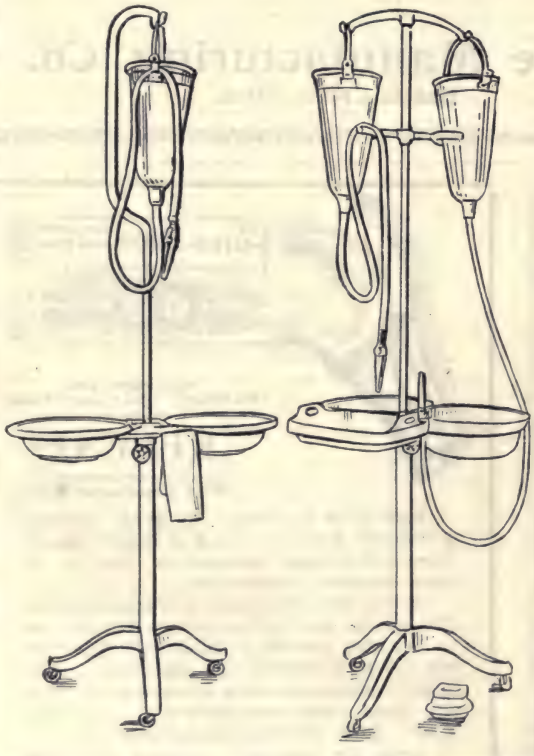

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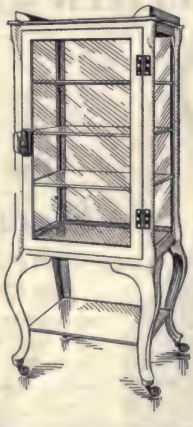

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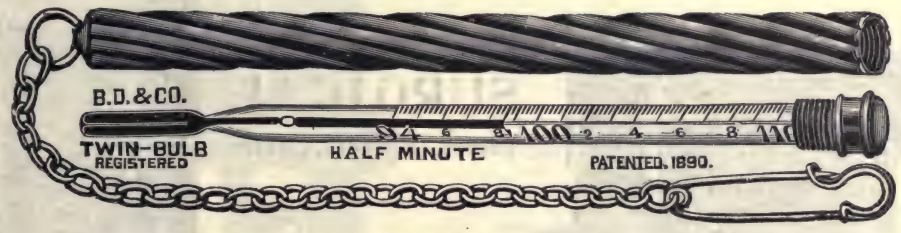

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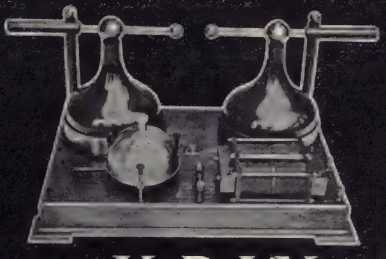

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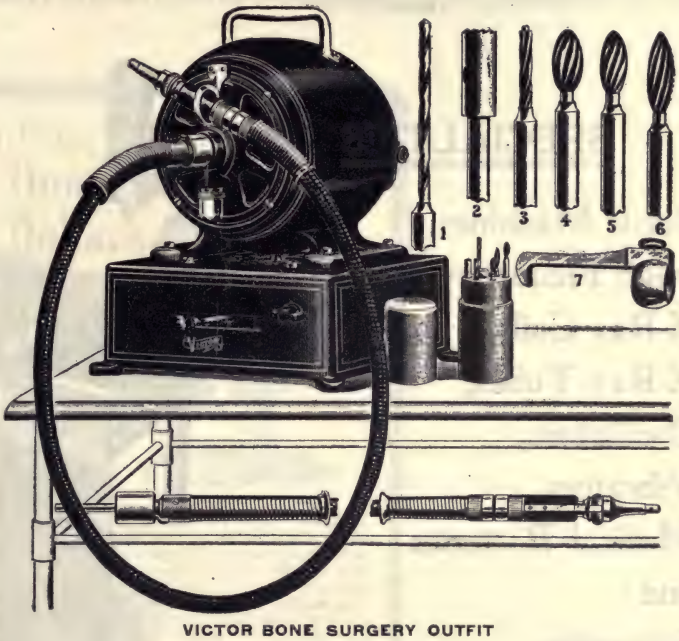

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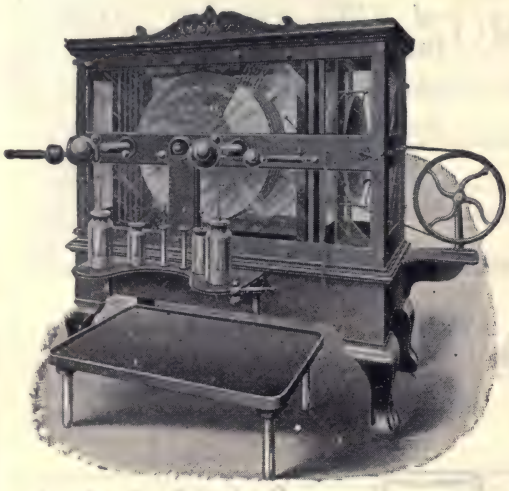

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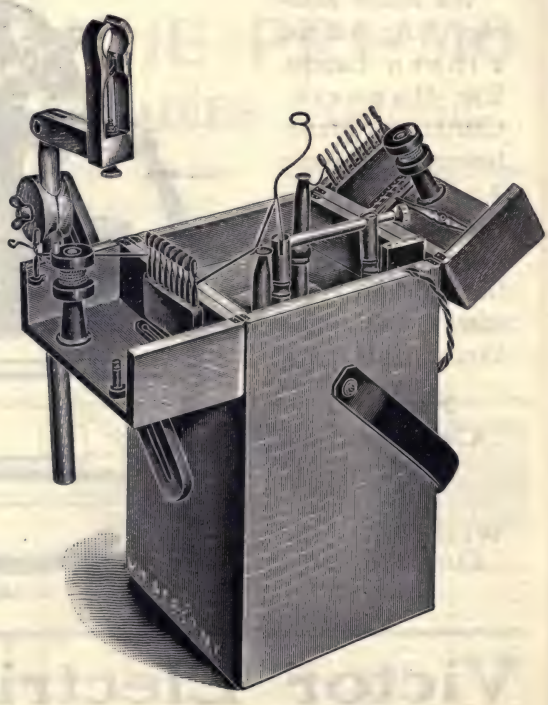

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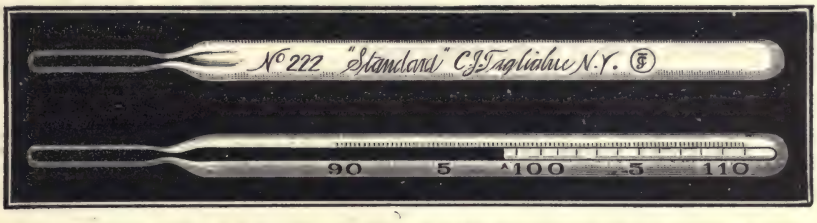

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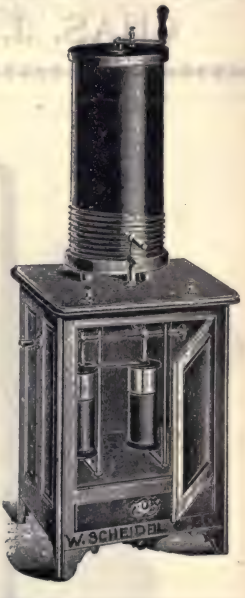

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